

State: Indiana **Filing Company:** Anthem Insurance Companies, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other
Product Name: IN 2015 - On- and Off-Exchange - SG
Project Name/Number: /

Filing at a Glance

Company: Anthem Insurance Companies, Inc.
Product Name: IN 2015 - On- and Off-Exchange - SG
State: Indiana
TOI: H16G Group Health - Major Medical
Sub-TOI: H16G.003G Small Group Only - Other
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Author(s): Terry Burns, Troy Wright, Michelle Brown, Aaron Smith, Pak Ko, Johnny Ko, Christopher Murrah, Wilson Wang, Judy Ding
Reviewer(s): Kim Isles (primary), Karl Knable, Vince Sherwin, Stephanie Williams
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Implementation Date: 01/01/2015

State Filing Description:
GRMM

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General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
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Submission Type: New Submission Group Market Size: Small
Group Market Type: Overall Rate Impact: 3.53%
Filing Status Changed: 08/08/2014
State Status Changed: Deemer Date:
Created By: Christopher Murrah Submitted By: Christopher Murrah
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

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

Filing Description:

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

The purpose of this rate filing is to establish rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). The rates will be in-force for effective dates on or after January 1, 2015. Subsequent rate changes will be implemented quarterly as discussed in more detail in Section 16: Index Rate. These rates will apply to plans offered both On-Exchange and Off-Exchange. This rate filing is not intended to be used for other purposes.

Also attached, for your review and approval, are forms ABCBS-SG HMO ON/OFF EXCH-v02, ABCBS-SG POS ON/OFF EXCH-v02 and ABCBS-SG PPO OFF EXCH-v02. These are updated HMO, POS & PPO small group certificates that we are submitting for use in 2015. These forms will be offered to new small groups effective in 2015; and, will be reissued as replacement forms to existing small groups on our previously approved 2014 certificates.

These new forms are identical to the small group HMO, POS and PPO on and off exchange certificates of coverage that we submitted for approval last year under SERFF filings # ANTA-128999967, ANTA-128940733, and ANTA- 129004712. Both clean certificates of coverage under the form schedule tab and a redline version under supporting documentation is included to show the changes made to last year's approved forms. Changes to last year's forms include the following:

- Minor adjustments to deductible & out of pocket amounts;
- Minor adjustments to cost shares;
- Addition of embedded pediatric dental benefit to HMO and POS plans;
- Removal of optional adult dental and vision benefits from PPO certificate
- Revisions to language in both schedule and covered services for compliance with Federal Mental Health Parity based on our interpretation of final regulations. For example, adding coverage for residential treatment centers.
- Revisions to language throughout certificate due to internal company updates.
- Last year, HMO on & off exchange and POS on and off exchange were filed as separate certificates. -We have combined

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into one HMO certificate for use on & off exchange and one POS certificate used on & off exchange. Any language used specifically for on exchange only or off exchange only is identified as such and is a bracketed item in the certificate.

Also attached are:

- Statements of variability to indicate how text in [brackets] will be used.
- HMO, POS and PPO Small Group Company Filing Checklists.
- EHB Crosswalk tolls and EHB templates

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

Company and Contact

Filing Contact Information

Aaron Smith, AICI Aaron.Smith@Wellpoint.com
220 Virginia Ave 317-287-6452 [Phone]
Indianapolis, IN 46204

Filing Company Information

Anthem Insurance Companies, CoCode: 28207 State of Domicile: Indiana
Inc. Group Code: 671 Company Type: Life,
220 Virginia Ave Group Name: WellPoint Inc Group Accident, Health
Indianapolis, IN 46204 FEIN Number: 35-0781558 State ID Number:
(800) 331-1476 ext. [Phone]

Filing Fees

Fee Required? Yes
Fee Amount: \$140.00
Retaliatory? No
Fee Explanation:
Per Company: Yes

Company	Amount	Date Processed	Transaction #
Anthem Insurance Companies, Inc.	\$140.00	05/09/2014	82108349

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Form Schedule

Lead Form Number: ABCBS-SG PPO OFF EXCH-v02								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		PPO Certificate of Coverage	ABCBS-SG PPO OFF EXCH-v02	CER	Initial		44.500	Indiana SG ABCBS SG PPO OFF EXCH v02 clean 042914.pdf
2		HMO Certificate of Coverage	ABCBS-SG HMO ON/OFF EXCH-v02	CER	Initial		41.700	Indiana ABCBS-SG HMO-ON-OFF EXCH-v02 clean.pdf
3		POS Certificate of Coverage	ABCBS-SG POS ON/OFF EXCH-v02	CER	Initial		40.800	Indiana SG ABCBS-SG POS-ON-OFF EXCH v02 clean.pdf

Form Type Legend:

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

Certificate of Coverage

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

**Anthem [Gold] [Silver] [Bronze] Blue Access PPO [Copayment or
Deductible/ Coinsurance/ Out-of-Pocket Limits] [Plus] [w/ HSA]**



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

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

Anthem Insurance Companies, Inc.

**[120 Monument Circle]
[Indianapolis, Indiana 46204]**

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, [\[www.anthem.com\]](http://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, [\[www.anthem.com\]](http://www.anthem.com)

Additional Federal Notices

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

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

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

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

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

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

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

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

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

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

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

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

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

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

[Standard, but can remove if a group is not subject to ERISA:

Statement of ERISA Rights

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

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

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

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

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

Notices Required by State Law

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

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

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

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

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

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

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

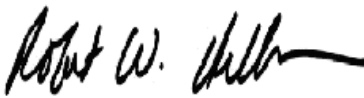
[Use with HSAs:

High-Deductible Health Plan for Use with Health Savings Accounts

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

How to Get Language Assistance

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



[President]

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Schedule of Benefits

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

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

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

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

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

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

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

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

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

Deductible	In-Network	Out-of-Network
Per Member	[\$1,000-\$6,300]	[\$2,000-\$12,600]
Per Family [– Aggregate/ Delete for non-embedded CDHP plans: All other Members combined]	[\$2,000-\$12,600]	[\$4,000-\$25,200]
[Option for Non-Embedded Plans (CDHP): If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amounts apply to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amounts apply.]) The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.		
Coinsurance	In-Network	Out-of-Network
Plan Pays	[100%-50%]	[70%-50%]
Member Pays	[0%-50%]	[30%-50%]
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		
Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	[\$2,000- \$6,600]	\$4,500- \$15,750]
Per Family [– Aggregate/ Delete for non-embedded CDHP plans: All other Members combined]	[\$4,000- \$13,200]	\$9,000- \$31,500]
[Option for Non-Embedded Plans: If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amounts apply to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amounts apply.] [Standard for plans with deductible, coinsurance and copays: The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.] [For plans that have deductible & coinsurance only, without copays: The Out-of-Pocket Limit includes all Deductibles and Coinsurance you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]		

Deductible	In-Network	Out-of-Network
The Out-of-Pocket Limit does not include amounts you pay for following benefits: Out-of-Network Human Organ and Tissue Transplant services. Once the Out-of- Pocket Limit is satisfied, you will not have to pay any additional [Use for plans with deductible, coinsurance and copays: Deductibles, Coinsurance, or Copayments] [Use for plans with deductible and coinsurance only: Deductibles or Coinsurance] for the rest of the Benefit Period [, except for the services listed above]. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

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

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

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water)	[\$100 Copayment] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Ambulance Services (Ground)	[\$100 Copayment] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.		

Benefits	In-Network	Out-of-Network
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	See “Mental Health and Substance Abuse Services.”	
Cardiac Rehabilitation	See “Therapy Services.”	
Chemotherapy	See “Therapy Services.”	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services for Members Through Age 18		
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• Diagnostic and Preventive Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Basic Restorative Services	40% Coinsurance after Deductible	50% Coinsurance after Deductible
• Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Dentally Necessary Orthodontic Care Waiting Period	12 months	

Benefits	In-Network	Out-of-Network
Advanced Diagnostic Imaging (including MRIs, CAT scans) Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.	[0%-50%] Coinsurance]	[no Deductible] [after Deductible]
Home Care		
Home Care Visits	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Dialysis	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Infusion Therapy	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Specialty Prescription Drugs	[\$10- \$50] Copayment] [per Drug] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Home Care Services / Supplies	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period, In- and Out-of-Network combined. The limit does not apply to Home Infusion Therapy or Home Dialysis.	
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period, In- and Out-of-Network combined 164 visits per Lifetime, In- and Out-of-Network combined	
Home Infusion Therapy	See "Home Care."	

Benefits	In-Network	Out-of-Network
Hospice Care - Home Care - Respite Hospital Stays		
	[No Copayment, Deductible, or Coinsurance] [0% Coinsurance] [no Deductible] [after Deductible]	[0%-50%] Coinsurance after Deductible
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Hospital / Acute Care Facility you will pay [0%-40%] Coinsurance] [no Deductible] [after Deductible]. [Please see [anthem.com] for a list of Preferred Facilities.]]		
Skilled Nursing Facility	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Skilled Nursing Facility you will pay [0%- 40%] Coinsurance] [no Deductible] [after Deductible]. [Please see [anthem.com] for a list of Preferred Facilities.]]		
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period, In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[For plans with hospital copay: Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.]		
[For plans with hospital copay: Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.]		

Benefits	In-Network	Out-of-Network
Doctor Services for: - General Medical Care / Evaluation and Management (E&M) - Surgery	[0%-50%] Coinsurance] [no Deductible] [after Deductible] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible [30%-50%] Coinsurance after Deductible
Maternity and Reproductive Health Services		
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal and delivery services) [Use only when copays apply: If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.]	[\$10- \$50] Copayment] [per pregnancy] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [Use only when OV copay applies: The Office Visit Copayment will also apply to the first prenatal visit.]	[30%-50%] Coinsurance after Deductible
Inpatient Services (Delivery)	See "Inpatient Services"	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services		
Inpatient Facility Services	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Inpatient Facility you will pay [0%- 50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Residential Treatment Center Services	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Inpatient Doctor Services	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Outpatient Facility Services	[0%-50%] Coinsurance] [after Deductible] [no Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [0%- 50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Outpatient Doctor Services	[0%- 50%] Coinsurance] [No Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendor Plans: Note: If you use a Preferred Partial Hospital/ Intensive Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Providers.]]		
Office Visits	[Covered in PCP / SCP Copayment] [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” in the “Additional Federal Notices” section for details.		
Occupational Therapy	See “Therapy Services.”	
Office Visits		
Primary Care Physician / Provider (PCP)	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[PC2: Note: If your PCP is part of our Enhanced Personal Health Care Program you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible].]		

Benefits	In-Network	Out-of-Network
Specialty Care Physician / Provider (SCP)	[\$20- \$75] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Retail Health Clinic Visit [Preferred Vendors: Note: If you use a Preferred Retail Health Clinic you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Clinics.]]	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Online Visit [Preferred Vendors: Note: If you use a Preferred Online Visit Provider you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Providers.]]	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Counseling- includes Family Planning and Nutritional Counseling (Other than Eating Disorders)	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Nutritional Counseling for Eating Disorders	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Allergy Testing	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Shots/Injections (other than allergy serum)	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic Lab (non-preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic X-ray (non-preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic Tests (non-preventive; including hearing and EKG)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Office Surgery	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Therapy Services: - Chiropractic Care & Spinal Manipulation	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Physical, Speech, & Occupational Therapy	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Dialysis / Hemodialysis	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Cardiac Rehabilitation & Pulmonary Therapy	[\$20- \$75] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (includes allergy serum)	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Optional if 3 visits apply: Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.]		
Orthotics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Outpatient Facility Services		
• Facility Surgery Charge	[0%-50%] Coinsurance] [after Deductible] [no Deductible]]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Doctor Surgery Charges	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Diagnostic Lab	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic X-ray	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible] for advanced diagnostic imaging services. [Please see anthem.com for a list of Preferred Facilities.]]		

Benefits	In-Network	Out-of-Network
- Therapy: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational Therapy - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Dialysis / Hemodialysis - Cardiac Rehabilitation & Pulmonary Therapy - See "Therapy Services" for details on Benefit Maximums. - Prescription Drugs Administered in an Outpatient Facility	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [\$20- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible [30%-50%] Coinsurance after Deductible [30%-50%] Coinsurance after Deductible [30%-50%] Coinsurance after Deductible [30%-50%] Coinsurance after Deductible [30%-50%] Coinsurance after Deductible
Physical Therapy	See "Therapy Services."	
Preventive Care	No Copayment, Deductible, or Coinsurance	[30%-50%] Coinsurance after Deductible
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	

Benefits	In-Network	Out-of-Network
Pulmonary Therapy	See “Therapy Services.”	
Radiation Therapy	See “Therapy Services.”	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See “Therapy Services.”	
Skilled Nursing Facility	See “Inpatient Services.”	
Speech Therapy	See “Therapy Services.”	
Surgery	Benefits are based on the setting in which Covered Services are received.	
[optional offer mandate – add when selected –Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime, In- and Out-of-Network combined]	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
- Physical Therapy - Occupational Therapy - Speech Therapy - Manipulation Therapy - Cardiac Rehabilitation	20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 36 visits per Benefit Period	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		

Benefits	In-Network	Out-of-Network
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	
Urgent Care Services (Office Visits)		
Urgent Care Office Visit Charge	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Testing	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Shots/ Injections (other than allergy serum)	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Office Surgery	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		
Vision Services for Members Through Age 18 Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam	\$0 Copayment	Covered up to \$30
Limited to one exam per Benefit Period		
Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Covered up to \$25
Bifocal	\$0 Copayment	Covered up to \$40
Trifocal	\$0 Copayment	Covered up to \$55
Progressive	\$0 Copayment	Covered up to \$40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost In-Network.		
Frames	\$0 Copayment	Covered up to \$45
Limited to one set of frames from the Anthem Formulary per Benefit Period.		
Contact Lenses		
Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this <i>before</i> you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further details.) The requirements described below do not apply to the following: • Cornea and kidney transplants, which are covered as any other surgery; and • Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service. Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the “What’s Covered” section for additional details.		
Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
• Precertification required	During the Transplant Benefit Period, [no Copayment / Deductible / Coinsurance.] [0% - 50%] Coinsurance]	During the Transplant Benefit Period, You will pay [30% -50%] Coinsurance after Deductible. During the

Benefits	In-Network	Out-of-Network
	[after Deductible] Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
	[No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30%-50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.

Benefits	In-Network	Out-of-Network
Transportation and Lodging	[Standard: No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.] [Option: Not covered]
• Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant, In- and Out-of-Network combined.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	[Standard: No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant, In- and Out-of-Network combined.	
Live Donor Health Services	[Standard: No Copayment/ Deductible/ Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. [Standard, but may remove for HSA plans that don't have copays: You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.] [Optional for Plans w/ Rx Deductible: Prescription Drug Deductible (Does not apply to Tier 1)		
[Per Member]	[\$250-\$500], In- and Out-of-Network combined]	
[Per Family]	[\$500- \$1,000], In- and Out-of-Network combined]	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
[Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments/Coinsurance listed below.]		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)		30 days
Home Delivery (Mail Order) Pharmacy		90 days
Specialty Pharmacy (In-Network and Out-of-Network)		30 days*
	*See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
[Use for HSA Plans: Note: The Prescription Drug Copayments listed below will not apply until after the Plan Deductible is met.]		
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$10- \$15] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 2 Prescription Drugs	[\$30- \$50] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 3 Prescription Drugs	[\$60- \$90] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 4 Prescription Drugs	[0%-50%] Coinsurance [to a maximum of \$250- \$500] [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$25- \$38] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered
Tier 2 Prescription Drugs	[\$75- \$125] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 3 Prescription Drugs	[\$150- \$225] Copayment] [0%-50%] Coinsurance] [after Deductible] per Prescription Drug	Not covered
Tier 4 Prescription Drugs	[0%-50%] Coinsurance] [to a maximum of [\$250- \$500] [after Deductible] per Prescription Drug	Not covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.		
[OPTIONAL-Brand Penalty: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.]		
[Regular PPO plans: Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]		
[HSA plans: Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]		
Orally Administered Cancer Chemotherapy	[Use with all regular plans: No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.	
	No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-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.]	
	[Use with HSA RX copay plans: After Deductible has been satisfied, no Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
After Deductible has been satisfied, you get from an Out-of-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.] [Use with HSA coinsurance plans: Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from an In-Network Pharmacy, Home Delivery Pharmacy, Specialty Pharmacy Network, or Non-Network Pharmacy.] 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.		

How Your Plan Works

Introduction

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

In-Network Services

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

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

To see a Doctor, call their office:

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

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

For services from In-Network Providers:

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

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

After Hours Care

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

Out-of-Network Services

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

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

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

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

Please note that not all In-Network Providers offer all services. For example, **when you need Outpatient lab services**, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

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

[PC2 option:

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Your Cost-Shares

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

Crediting Prior Plan Coverage

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

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

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

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

This Section Does Not Apply To You If:

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

The BlueCard® Program

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

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

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

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

Care Outside the United States – BlueCard® Worldwide

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

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your up to date Anthem Identification Card.

- In an Emergency, go straight to the nearest Hospital.
- The BlueCard® Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

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

Payment Details

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

Claim Filing

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

Claim Forms

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

Identification Card

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

Getting Approval for Benefits

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

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

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

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

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

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by a BlueCard®/Out-of-Network/Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

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

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

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

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

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

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

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

Request Categories

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

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

Decision and Notice Requirements

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

Request Category	Timeframe Requirement for Decision and Notification
<i>Precertification Requests</i>	
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
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
<i>Predetermination Requests</i>	
Prospective Urgent	72 hours from the receipt of request
Prospective Non- Urgent	15 calendar days from the receipt of the request
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request

Continued Stay Review 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
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request

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

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

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

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

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

For benefits to be covered, on the date you get service:

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

Health Plan Individual Case Management

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

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

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

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

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

What's Covered

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

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

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

Allergy Services

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

Ambulance Services

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

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

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

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

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

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Clinical Trials

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

Benefits are limited to the following trials:

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

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

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

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

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

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this plan.

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

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

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

Pretreatment Estimate

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

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

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

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

Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

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

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

Radiographs (X-rays)

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

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

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

Fluoride Varnish Covered 2 times per calendar year.

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

Space Maintainers.

Recement Space Maintainer.

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

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

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

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

Recement inlay and crown.

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

Protective Restoration.

Pin Retention- per tooth, in addition to restoration.

Other Adjunctive General Services

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

Endodontic Services

Endodontic Therapy on Primary Teeth

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

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments Limited to once per tooth per lifetime:

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

Periodontal Services

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

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

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

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

Crown Lengthening

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

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

Complex surgical periodontal services are limited as follows:

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

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

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

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

Other Complex Surgical Procedures

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

Other Oral Surgery Procedures

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

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

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

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

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

Implant Crowns See "Prosthodontic Services".

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

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

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

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

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

Prosthodontic Services

Tissue Conditioning

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

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

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

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

Denture Adjustments Covered when:

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

Partial and Bridge Adjustments Covered when:

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

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

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

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

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

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

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

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

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. [*Ortho / Dental Necessity option*: We will only cover Dentally Necessary orthodontic care. To be considered Dentally Necessary at least one of the following must be present:

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

Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.]

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

Benefits may include the following:

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

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

Benefits do not include:

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

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

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

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

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

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

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self-management training if you have 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.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

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

Dialysis

See "Therapy Services" later in this section.

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

Durable Medical Equipment and Medical Devices

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

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

- Is made to serve a medical use.
- Is ordered by a Provider.

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

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

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

Orthotics

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

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.

Prosthetics

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

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

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

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

Blood and Blood Products

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

Emergency Care Services

Emergency Services

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

Emergency (Emergency Medical Condition)

“Emergency” or “Emergency Medical Condition” means 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 layperson who possesses an average knowledge of health and medicine to: (a) place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

“Stabilize” means 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.

Emergency Care

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

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

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

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

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

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

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

Home Care Services

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

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

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

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

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

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

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

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

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

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

Covered Transplant Procedure

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

In-Network Transplant Provider

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

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

Out-of-Network Transplant Provider

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

Transplant Benefit Period

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

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

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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

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

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

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

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

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

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

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

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

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

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

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

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

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

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Optional: Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.]

[Optional: Sterilization Services]

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

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Infertility Services

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

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

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

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

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

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

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

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

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

Urgent Care as described in “Urgent Care Services” later in this section.

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

Prescription Drugs Administered in the Office

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

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

- Diagnostic services,
- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children with no current symptoms or history of a health problem.

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

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women’s contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”]
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per [Standard: pregnancy] [Benefit Period].
 - c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government’s web sites, <http://www.healthcare.gov/what-are-my-preventive-care-benefits>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/recs/acip/>.

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

Prosthetics

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

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

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

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

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

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

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

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

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

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

[Mandated-Optional benefit – add only when selected:

Bariatric Surgery

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.]

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

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

Your Plan also covers certain oral surgeries for children. Please refer to “Dental Services for Members Through Age 18” for details.

Reconstructive Surgery

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

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

Mastectomy Notice

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

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

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

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

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

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

Benefits for urgent care include:

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

Vision Services for Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

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

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In-Network.

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

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

Frames

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

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

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

Vision Services (All Members / All Ages)

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

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

Prescription Drugs Administered by a Medical Provider

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

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

Important Details About Prescription Drug Coverage

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

Prior Authorization

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

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

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

Step Therapy

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

Therapeutic Substitution

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

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

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

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

Prescription Drug Benefits

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

Covered Prescription Drugs

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

Benefits are available for the following:

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

- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a Member age 18 or older. These products will be covered under the “Preventive Care” benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

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

Home Delivery Pharmacy

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

Specialty Pharmacy

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

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

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

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Out-of-Network Pharmacy

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

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;

- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

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

What You Pay for Prescription Drugs

Tiers

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

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs. This tier contains higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

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

Prescription Drug List

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

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

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

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

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

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

Half-Tablet Program

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

[Standard for all plans except HSA: Special Programs

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

What's Not Covered

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

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

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details.
- 2) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
- 3) **Administrative Charges**
 - a) Charges to complete claim forms,
 - b) Charges to get medical records or reports,
 - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - a. Acupuncture,
 - b. Holistic medicine,
 - c. Homeopathic medicine,
 - d. Hypnosis,
 - e. Aroma therapy,
 - f. Massage and massage therapy,
 - g. Reiki therapy,
 - h. Herbal, vitamin or dietary products or therapies,
 - i. Naturopathy,
 - j. Thermography,
 - k. Orthomolecular therapy,
 - l. Contact reflex analysis,
 - m. Bioenergetic synchronization technique (BEST),
 - n. Iridology-study of the iris,
 - o. Auditory integration therapy (AIT),
 - p. Colonic irrigation,
 - q. Magnetic innervation therapy,
 - r. Electromagnetic therapy.
- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

- 6) **Certain Providers** Service you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

15) Dental Services

- a) Dental care for Members age 19 or older.
- b) Dental services not listed as covered in this Booklet.
- c) Oral hygiene instructions.
- d) Case presentations.
- e) Athletic mouth guards, enamel microabrasion and odontoplasty.
- f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- h) Pulp vitality tests.
- i) Adjunctive diagnostic tests.
- j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.

- l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
 - m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
 - n) Incomplete root canals.
 - o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
 - p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - q) Provisional splinting, temporary procedures or interim stabilization.
 - r) Services of anesthesiologists, unless required by law.
 - s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
 - t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
 - u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
 - v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - w) Canal prep & fitting of preformed dowel & post.
 - x) Temporary, provisional or interim crown.
 - y) Occlusal procedures.
 - z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
 - aa) Pin retention is not covered when billed separately from restoration procedure.
 - bb) Services for the replacement of an existing partial denture with a bridge.
 - cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
 - dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
 - ee) Separate services billed when they are an inherent component of another covered service.
 - ff) Cone beam images.
 - gg) Anatomical crown exposure.
 - hh) Temporary anchorage devices.
 - ii) Sinus augmentation.
 - jj) Repair or replacement of lost/broken appliances.
- 16) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
- 17) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the criteria we use to determine if a Service is Experimental or Investigational is outlined below.

- 18) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 19) **Eye Exercises** Orthoptics and vision therapy.
- 20) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 21) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 22) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
 - a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 23) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.
- 24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers' Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- 27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- 29) **Infertility Treatment** Testing or treatment related to infertility.
- 30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

31) **Medical Equipment and Supplies**

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- c) Non-Medically Necessary enhancements to standard equipment and devices.

32) **Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

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

34) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

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

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

37) **Personal Care and Convenience**

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

38) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.

39) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

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

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

42) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.

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

44) **[Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]

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

- 46) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 47) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 48) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 49) **Vision Services**
- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
 - b) Safety glasses and accompanying frames.
 - c) For two pairs of glasses in lieu of bifocals.
 - d) Plano lenses (lenses that have no refractive power).
 - e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
 - f) Vision services not listed as covered in this Booklet.
 - g) Cosmetic lenses or options.
 - h) Blended lenses.
 - i) Oversize lenses.
 - j) Sunglasses and accompanying frames.
 - k) For services or supplies combined with any other offer, coupon or in-store advertisement.
 - l) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
 - m) Certain frames in which the manufacturer imposes a no discount policy.
- 50) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

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

[Add if group chooses to cover Bariatric Surgery per mandate option: This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

- 51) **[Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery]** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.]

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. **[Optional non-standard: Clinically-Equivalent Alternatives]** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

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

3. **Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.

[Religious group opt out to exclude Contraceptive drugs:

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "**Prescription Drugs Administered by a Medical Provider**" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments. While these services are not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they may be covered under the "Dental Services for Members Through Age 18" benefit. Please see that section for further details.
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.

15. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these may be covered under the “Allergy Services” benefit. Please see that section for details.
16. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
18. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one or more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

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

Maximum Allowed Amount General

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

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

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

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

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

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

Provider Network Status

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

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

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

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

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

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

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

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

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

Member Cost Share

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

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

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

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

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

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

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

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

- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.
- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of \$1500, or \$450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

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

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

Example:

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

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

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

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

Claims Review

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

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

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

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.

Claim Forms

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

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

Member's Cooperation

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

Payment of Benefits

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

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

Inter-Plan Programs

Out-of-Area Services

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

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

BlueCard® Program

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

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

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

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

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

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

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

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

Exceptions

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

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

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

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. An Out-of-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 [(carve-out) Medicare,] 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 generally 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.

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.

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

Subrogation

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

- We have 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.

Member Rights and Responsibilities

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

You have the right to:

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

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.

- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

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

If you need more information or would like to contact us, please go to [anthem.com](https://www.anthem.com) and select Customer Support > Contact Us. Or call the Member Services number on your ID card

Grievance and External Review Procedures

Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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.

We will also accept Grievances filed in writing, including by facsimile or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-800-368-3238] if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

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

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 five (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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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.

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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the 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.]

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Subscriber

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

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

Dependents

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

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- **[Domestic partner coverage:** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who **[Standard only when affidavit used:** has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard only when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

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

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

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

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

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

Types of Coverage

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

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- Subscriber and child(ren);
- Subscriber and family.

When You Can Enroll

Initial Enrollment

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

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

[Standard / Open Enrollment: Open Enrollment

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

Special Enrollment Periods

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

Special Enrollment is available for eligible individuals who:

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

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

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

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

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

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

Medicaid and Children's Health Insurance Program Special Enrollment

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

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

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

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

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

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

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

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

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

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

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

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

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

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

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

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

Termination and Continuation of Coverage

Termination

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

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying Us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

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

Removal of Members

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

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

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

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

Continuation of Coverage Under Federal Law (COBRA)

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

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

Qualifying events for Continuation Coverage under Federal Law (COBRA)

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

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

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Dependents:</u> A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

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

If Your Group Offers Retirement Coverage

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

Second qualifying event

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

Notification Requirements

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

You Must Give Notice of Some Qualifying Events

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

Electing COBRA Continuation Coverage

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

Disability extension of 18-month period of continuation coverage

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

Trade Adjustment Act Eligible Individual

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

When COBRA Coverage Ends

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

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

If You Have Questions

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

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave. Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

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

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

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

College Student Medical Leave

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

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

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

Family and Medical Leave Act of 1993

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

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

General Provisions

Assignment

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

Clerical Error

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

Confidentiality and Release of Information

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

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

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

Conformity with Law

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

Contract with Anthem

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

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

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

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

Form or Content of Booklet

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

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.

Government Programs

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

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

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

Not Liable for Provider Acts or Omissions

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

Policies and Procedures

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

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

Relationship of Parties (Group-Member-Anthem)

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

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Reservation of Discretionary Authority

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

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

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

Right of Recovery

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

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

Unauthorized Use of Identification Card

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

Value-Added Programs

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

Value of Covered Services

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

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

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

Workers' Compensation

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

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

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

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

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

Athletic Trainer

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

Authorized Service(s)

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

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

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

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

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

Copayment

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

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in “Benefits After Termination.”

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

Covered Transplant Procedure

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

Custodial Care

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

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

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

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

Deductible

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

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

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

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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 "What's Not Covered" section.

Facility

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

Generic Drugs

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

Group

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

Group Contract (or Contract)

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

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

Home Health Care Agency

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

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

Hospice

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

Hospital

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

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

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

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

Identification Card

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

In-Network Provider

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

In-Network Transplant Provider

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

Inpatient

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

Late Enrollees

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

Maximum Allowed Amount

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

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

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

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

[Open Enrollment

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

Out-of-Network Provider

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

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

Out-of-Network Transplant Provider

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

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does **not** include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn’t cover. Please see the “Schedule of Benefits” for details.

Pharmacy

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

Pharmacy and Therapeutics (P&T) Process

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

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

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

Plan

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

Precertification

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

Predetermination

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

Premium

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

Prescription Drug (Drug)

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

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 2) Insulin, diabetic supplies, and syringes.

Primary Care Physician ("PCP")

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

Primary Care Provider

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

Provider

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

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

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

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

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

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

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

Specialist (Specialty Care Physician \ Provider or SCP)

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

Specialty Drugs

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

Subscriber

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

Transplant Benefit Period

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

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Certificate of Coverage

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

Anthem [Gold][Silver][Bronze] Blue Preferred [on exchange only: X] HMO
[Insert INN Cost Share: Copay or Deductible / Coinsurance / OOP
Limit] [Plus] [w/HSA]



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

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

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

Anthem Insurance Companies, Inc.

**[120 Monument Circle]
[Indianapolis, Indiana 46204]**

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, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, [www.anthem.com]

Additional Federal Notices

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

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

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

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

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

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

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

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

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

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

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

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

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

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

[Standard, but can remove if a group is not subject to ERISA:]

Statement of ERISA Rights

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

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

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

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

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

Notices Required by State Law

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

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

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

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

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

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

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

[Use with HSAs:

High-Deductible Health Plan for Use with Health Savings Accounts

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

How to Get Language Assistance

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



[

President

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Schedule of Benefits

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

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

To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, Urgent Care, or Authorized Services. Please be sure to contact us if you are not sure if we have approved an Authorized Service. Benefits are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an approved Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for additional details.

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

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

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

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

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

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

Deductible	In-Network
[Per Member]	[\$1,250-6,000]
[Per Family [Delete for non-embedded HSA plans – All other Members combined]]	[\$2,500-12,000]
[Option for Non-Embedded HSA Plans: If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amount applies to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amount applies.)] When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.	

Coinsurance	In-Network
Plan Pays	[90%-70%]
Member Pays	[10%-30%]
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an approved Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.	

Out-of-Pocket Limit	In-Network
[Per Member]	[\$4,500-6,600]
[Per Family [Delete for Non-Embedded HSA Plans – All other Members combined]]	[\$9,000-\$13,200]
[Option for Non-Embedded HSA Plans: If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amount applies to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amount applies.)] The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or charges for non-Covered Services. Once the Out-of- Pocket Limit is satisfied, you will not have to pay additional [Deductibles or Coinsurance][Deductibles, Coinsurance, or Copayments] for the rest of the Benefit Period, except for the services listed above.	

Important Notice about Your Cost Shares

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

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

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Ambulance Services (Air and Water)	[10%-30%] Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Ambulance Services (Ground)	[10%-30%] Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	Not Covered
Behavioral Health Services	See "Mental Health and Substance Abuse Services."	Not covered
Cardiac Rehabilitation	See "Therapy Services."	Not covered
Chemotherapy	See "Therapy Services."	Not covered

Benefits	In-Network	Out-of-Network
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	Not covered
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	Not covered
Dental Services Accidental Injury Benefit Maximum	\$3,000 per Accidental Injury	Not covered
Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that we are required to cover by law.		
Dental Services For Members Through Age 18 Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• Diagnostic and Preventive Services	10% Coinsurance after Deductible	Not covered
• Basic Restorative Services	40% Coinsurance after Deductible	Not covered
• Endodontic Services	50% Coinsurance after Deductible	Not covered
• Periodontal Services	50% Coinsurance after Deductible	Not covered
• Oral Surgery Services	50% Coinsurance after Deductible	Not covered
• Major Restorative Services	50% Coinsurance after Deductible	Not covered
• Prosthodontic Services	50% Coinsurance after Deductible	Not covered
• Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	Not covered
Dentally Necessary Orthodontic Care Waiting Period	12 months	Not covered

Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	Not covered
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	Not covered
[Optional/not for HSAs - Note: If you use a Preferred Diagnostic Lab (i.e., reference labs), you may not have to pay a Copayment, Deductible, or Coinsurance. Please see anthem.com for a list of these labs.]		
Dialysis	See "Therapy Services."	Not covered
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	[10%-30%] Coinsurance after Deductible	Not covered
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period	Not covered
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.		
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [Copayment waived if admitted]	
Emergency Room Doctor Charge	[10%-30%] Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
- Other Facility Charges (including diagnostic x-ray and lab services, medical supplies) - Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible	
Home Care		
Home Care Visits	[10%-30%] Coinsurance after Deductible	Not covered
Home Dialysis	[10%-30%] Coinsurance after Deductible	Not covered
Home Infusion Therapy	[10%-30%] Coinsurance after Deductible	Not covered
Specialty Prescription Drugs	[10%-30%] Coinsurance after Deductible	Not covered
Other Home Care Services / Supplies	[10%-30%] Coinsurance after Deductible	Not covered
Home Care Benefit Maximum	100 visits per Benefit Period The limit does not apply to Home Infusion Therapy or Home Dialysis.	Not covered
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period 164 visits per Lifetime	Not covered
Home Infusion Therapy		
	See "Home Care."	Not covered
Hospice Care		
- Home Care - Respite Hospital Stays	0% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	Not covered
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Skilled Nursing Facility	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period	Not covered
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	[10%-30%] Coinsurance after Deductible	Not covered
[For plans with hospital copay: Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.] [For plans with hospital copay: Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.]		
Doctor Services for:		
General Medical Care / Evaluation and Management (E&M)	[10%-30%] Coinsurance after Deductible	Not covered
Surgery	[10%-30%] Coinsurance after Deductible	Not covered
Maternity and Reproductive Health Services		

Benefits	In-Network	Out-of-Network
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.	[10%-30%] Coinsurance after Deductible [Use only when office visit copay applies: The Office Visit Copayment will also apply to the first prenatal visit.]	Not covered
Inpatient Services (Delivery)	See "Inpatient Services"	Not covered
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services		
Inpatient Facility Services	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Residential Treatment Center Services	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible]	Not Covered
Inpatient Doctor Services	[10%-30%] Coinsurance after Deductible	Not covered
Outpatient Facility Services	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
Outpatient Doctor Services	[10%-30%] Coinsurance after Deductible	Not covered
Partial Hospitalization Program / Intensive Outpatient Services	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
Office Visits	[[\$30-35] Copayment per visit for the first [3] visits, then] [10%-30%] Coinsurance after Deductible	Not covered
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.		
Occupational Therapy	See "Therapy Services."	Not covered

Benefits	In-Network	Out-of-Network
Office Visits		
• Primary Care Physician / Provider (PCP)	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Specialty Care Physician / Provider (SCP)	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Retail Health Clinic Visit	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Online Visit	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Counseling - Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	[10%-30%] Coinsurance after Deductible	Not covered
• Nutritional Counseling for Eating Disorders	[10%-30%] Coinsurance after Deductible	Not covered
• Allergy Testing	[10%-30%] Coinsurance after Deductible	Not covered
• Allergy Shots / Injections (other than allergy serum)	[10%-30%] Coinsurance after Deductible	Not covered
• Preferred Diagnostic Labs (i.e., reference labs)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Lab (non-preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic X-ray (non-preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Tests (non-preventive; including hearing and EKG)	[10%-30%] Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible	Not covered
• Office Surgery	[10%-30%] Coinsurance after Deductible	Not covered
• Therapy Services:		Not covered
- Chiropractic Care & Spinal Manipulation	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
- Physical, Speech, & Occupational Therapy - Dialysis / Hemodialysis - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Cardiac Rehabilitation & Pulmonary Therapy See "Therapy Services" for details on Benefit Maximums.	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered Not covered Not covered Not covered
• Prescription Drugs Administered in the Office (includes allergy serum)	[10%-30%] Coinsurance after Deductible	Not covered
[Not for use with coinsurance only plans or HSA plans: Important Note on Office Visit Copayments: Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.]		
Orthotics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	Not covered
Outpatient Facility Services		
• Facility Surgery Charge • Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies) • Doctor Surgery Charges • Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible	Not covered Not covered Not covered Not covered

Benefits	In-Network	Out-of-Network
• Other Facility Charges (for procedure rooms or other ancillary services) • Diagnostic Lab • Diagnostic X-ray • Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive) • Advanced Diagnostic Imaging (including MRIs, CAT scans) • Therapy: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Dialysis / Hemodialysis - Cardiac Rehabilitation & Pulmonary Therapy • Prescription Drugs Administered in an Outpatient Facility See "Therapy Services" for details on Benefit Maximums.	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible	- Not covered - Not covered - Not covered - Not covered - Not covered - Not covered - Not covered - Not covered - Not covered - Not covered
Physical Therapy	See "Therapy Services."	Not covered
Preventive Care	No Copayment, Deductible, or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
Prosthetics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	Not covered
Pulmonary Therapy	See “Therapy Services.”	Not covered
Radiation Therapy	See “Therapy Services.”	Not covered
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Respiratory Therapy	See “Therapy Services.”	Not covered
Skilled Nursing Facility	See “Inpatient Services.”	Not covered
Speech Therapy	See “Therapy Services.”	Not covered
Surgery	Benefits are based on the setting in which Covered Services are received.	Not covered
• [<i>optional offer mandate – add when selected</i> Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime]	Not covered
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	Not covered
Therapy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Benefit Maximum(s):	Benefit Maximum(s) are for office and outpatient visits combined.	Not covered
• Physical Therapy	20 visits per Benefit Period	Not covered

Benefits	In-Network	Out-of-Network
Occupational Therapy	20 visits per Benefit Period	Not covered
Speech Therapy	20 visits per Benefit Period	Not covered
Manipulation Therapy	20 visits per Benefit Period	Not covered
Cardiac Rehabilitation	36 visits per Benefit Period	Not covered
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	Not covered
Urgent Care Services (Office Visit) - Urgent Care Office Visit Charge [10%-30%] Coinsurance after Deductible - Allergy Testing [10%-30%] Coinsurance after Deductible - Allergy Shots / Injections (other than allergy serum) [10%-30%] Coinsurance after Deductible - Preferred Diagnostic Labs (i.e., reference labs) [10%-30%] Coinsurance after Deductible - Other Charges (e.g., diagnostic x-ray and lab services, medical supplies) [10%-30%] Coinsurance after Deductible - Advanced Diagnostic Imaging (including MRIs, CAT scans) [10%-30%] Coinsurance after Deductible - Office Surgery [10%-30%] Coinsurance after Deductible - Prescription Drugs Administered in the Office (includes allergy serum) [10%-30%] Coinsurance after Deductible		

Benefits	In-Network	Out-of-Network
If you see an Out-of-Network Provider, that Provider may also bill you for any charges over the Plan's Maximum Allowed Amount.		
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		

Vision Services For Members Through Age 18

Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.

- | | | |
|---------------------------|---------------|-------------|
| • Routine Eye Exam | \$0 Copayment | Not covered |
|---------------------------|---------------|-------------|

Limited to one exam per Benefit Period

• **Standard Plastic Lenses**

Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.

Single Vision	\$0 Copayment	Not covered
Bifocal	\$0 Copayment	Not covered
Trifocal	\$0 Copayment	Not covered
Progressive	\$0 Copayment	Not covered

Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.

- | | | |
|-----------------|---------------|-------------|
| • Frames | \$0 Copayment | Not covered |
|-----------------|---------------|-------------|

Limited to one set of frames from the Anthem Formulary per Benefit Period.

• **Contact Lenses**

Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.

Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Not covered
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Not covered
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye)		
Benefits are based on the setting in which Covered Services are received.		Not covered
Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		

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

Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further information.)

The requirements described below do not apply to the following:

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

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

Transplant Benefit Period

In-Network Transplant Provider

Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call

Out-of-Network Transplant Provider

Not covered

	the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	
	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, [Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
Precertification required	Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits or Office Visits depending where the service is performed.	
	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
Covered Transplant Procedure during the Transplant Benefit Period	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
Transportation and Lodging	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
Transportation and Lodging Limit	Covered, as approved by us, up to [\$10,000] per transplant	Not covered
Unrelated donor searches from an authorized,	[Standard: No Copayment	Not covered

licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure		/ Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	
• Donor Search Limit		Covered, as approved by us, up to [\$30,000] per transplant.	Not covered
Live Donor Health Services		[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
• Donor Health Service Limit		Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits

Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.

[Option: Prescription Drug Deductible (waived for Tier 1)

Per Member [\$250, 750]

Per Family [\$500, 1,500]]

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

Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits

Retail Pharmacy	30 days
Home Delivery (Mail Order) Pharmacy	90 days
Specialty Pharmacy	30 days*

*See additional information in the "Specialty Drug Copayments / Coinsurance" section below.

	In-Network	Out-of-Network
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$15 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 2 Prescription Drugs	[\$35, 50 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 3 Prescription Drugs	[\$70, 90 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 4 Prescription Drugs	[10%, 30% Coinsurance] [to a maximum of \$500] per Prescription Drug [after Deductible]	Not covered

Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$38 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 2 Prescription Drugs	[\$88, 125 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 3 Prescription Drugs	[\$175, 225 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 4 Prescription Drugs	[10%, 30% Coinsurance] [to a	Not covered

maximum of \$500] per Prescription Drug [after Deductible]	
Specialty Drug Copayments / Coinsurance:	
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy. [Optional: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will be have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.] [Standard: Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.] [HSA plans Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]	
Orally Administered Cancer Chemotherapy	<i>[Use with all regular plans</i> - No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.] <i>[Use with HSA coinsurance plans</i> - Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.] 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.

How Your Plan Works

Introduction

Your Plan is a HMO plan. To get benefits for Covered Services, you must use In-Network Providers, unless we have approved an Authorized Service or if your care involves an Emergency or Urgent Care situation.

In-Network Provider Services

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

Primary Care Physicians / Providers (PCP)

PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, and geriatricians. Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

If, when you first enroll (sign up) for coverage under this Plan, you are under the care of an Out-of-Network Provider, you should tell us right away. To keep getting care under this Plan from any Out-of-Network Provider, we must approve an Authorized Service with that Provider or the services will be denied.

First - Make an Office Visit with Your PCP

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

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

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

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

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

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

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

After Hours Care

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

[off exchange only: Guest Memberships]

When you or any of your covered dependents will be staying temporarily outside of the Service Area for more than 90 days, you can request a guest membership to a Blue Cross and Blue Shield affiliated health maintenance organization in that area. An example of when this service may be utilized is when a Dependent student attends a school outside of the service area. Call Customer Services at the number on the back of your ID card to make sure that the area in which you or your Dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated health maintenance organization plans. If the area is within the network, you will need to complete a guest membership application and you will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield health maintenance organization affiliate where you or your covered Dependents will be staying. A Customer Services representative will explain any limitations or restrictions to this benefit. If you are staying in an area that is not within the Guest Membership Network, this service will not be available.]

How to Find a Provider in the Network

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

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

Please note that not all In-Network Providers offer all services. For example, **when you need Outpatient lab services**, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

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

Service Area

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

[PC2 option:

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Termination of Providers

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

Your Cost-Shares

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

[off-exchange only - Crediting Prior Plan Coverage

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

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

If Your Group offers more than one of our products, and You change from one product to another with no break in coverage, You will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If Your Group offers coverage through other products or carriers in addition to ours, and You change products or carriers to enroll in this product with no break in coverage, You will get credit for any accrued Deductible, Out-of-Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or

- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.]

The BlueCard Program

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

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

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider.

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

Care Outside the United States – BlueCard® Worldwide

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

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

Call the Service Center in these non-emergency situations:

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

Payment Details

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

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.

- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

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

Identification Card

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

Getting Approval for Benefits

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

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

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

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

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

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

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

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

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

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

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

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

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

Request Categories

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

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

Decision and Notice Requirements

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

Request Category	Timeframe Requirement for Decision and Notification
<i>Precertification Requests</i>	
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
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
<i>Predetermination Requests</i>	
Prospective Urgent	72 hours from the receipt of request
Prospective Non- Urgent	15 calendar days from the receipt of the request
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request

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

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

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

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

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

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

Health Plan Individual Case Management

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

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

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

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

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

What's Covered

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

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

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

Allergy Services

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

Ambulance Services

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

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

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available.

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

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

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Clinical Trials

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

Benefits are limited to the following trials:

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

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

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

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

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

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

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

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

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

Pretreatment Estimate

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

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

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

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

Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

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

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

Radiographs (X-rays)

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

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

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

Fluoride Varnish Covered 2 times per calendar year.

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

Space Maintainers.

Recement Space Maintainer.

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

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

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

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

Re-cement inlay and crown.

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

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

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

Endodontic Services**Endodontic Therapy on Primary Teeth**

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

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

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

Periodontal Services

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

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

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

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

Crown Lengthening.

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

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;

- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

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

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

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

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

Other Complex Surgical Procedures

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

Other Oral Surgery Procedures

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

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

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

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

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

Implant Crowns See "Prosthodontic Services".

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

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

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

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

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

Prosthodontic Services

Tissue Conditioning.

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

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

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

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

Denture Adjustments Covered when:

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

Partial and Bridge Adjustments Covered when:

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

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

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

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

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

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

Recement Fixed Prosthetic.

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

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

Orthodontic Care

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

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

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

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

Benefits may include the following:

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

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

Benefits do not include:

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

Orthodontic Payments

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

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

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

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self management training if you have 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.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

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

Dialysis

See "Therapy Services" later in this section.

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

Durable Medical Equipment and Medical Devices

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

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

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

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

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

Orthotics

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

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.

Prosthetics

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

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

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;

- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

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

Blood and Blood Products

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

Emergency Care Services

Emergency Services

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

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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: (a)

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

"Stabilize" means 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.

Emergency Care

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

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

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

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

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

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

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

Home Care Services

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

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

See “Therapy Services” later in this section.

Hospice Care

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

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

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

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

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

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

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

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

Covered Transplant Procedure

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

In-Network Transplant Provider

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

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

Out-of-Network Transplant Provider

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

Transplant Benefit Period

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

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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

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

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

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

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

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

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,

- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

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

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

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

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

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

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

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.]

[Sterilization Services

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

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Infertility Services

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

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

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),

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

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

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

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

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

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

Urgent Care as described in “Urgent Care Services” later in this section.

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

Prescription Drugs Administered in the Office

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

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

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children with no current symptoms or history of a health problem.

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

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women’s contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”]
 - b. Breastfeeding support, supplies, and counseling. [Standard Benefits for breast pumps are limited to [1-10 one] pump per [Standard pregnancy] [Benefit Period].]
 - c. Gestational diabetes screening.

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

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

Prosthetics

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

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

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

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

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

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

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

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

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

[Mandated-Optional benefit – add only when selected:

Bariatric Surgery

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.]

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

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

Reconstructive Surgery

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

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

Mastectomy Notice

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

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

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

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

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.

- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

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

Benefits for urgent care include:

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

Vision Services For Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

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

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In Network.

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

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

Frames

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

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

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

Vision Services (All Members / All Ages)

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

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

Prescription Drugs Administered by a Medical Provider

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

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

Important Details About Prescription Drug Coverage

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

Prior Authorization

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

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

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

Step Therapy

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

Therapeutic Substitution

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

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

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

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

Prescription Drug Benefits

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

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- [Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

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

Home Delivery Pharmacy

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

Specialty Pharmacy

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

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

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

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at [www.anthem.com].]

What You Pay for Prescription Drugs

Tiers

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

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth,

shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

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

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the “Schedule of Benefits.” In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

[Standard for all plans except HSA:

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.]

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details. .
- 2) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
- 3) **Administrative Charges**
 - a) Charges to complete claim forms,
 - b) Charges to get medical records or reports,
 - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - a. Acupuncture,
 - b. Holistic medicine,
 - c. Homeopathic medicine,
 - d. Hypnosis,
 - e. Aroma therapy,
 - f. Massage and massage therapy,
 - g. Reiki therapy,
 - h. Herbal, vitamin or dietary products or therapies,
 - i. Naturopathy,
 - j. Thermography,
 - k. Orthomolecular therapy,
 - l. Contact reflex analysis,
 - m. Bioenergetic synchronization technique (BEST),
 - n. Iridology-study of the iris,
 - o. Auditory integration therapy (AIT),
 - p. Colonic irrigation,
 - q. Magnetic innervation therapy,
 - r. Electromagnetic therapy.

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence..
- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

15) Dental Services

- a) Dental care for Members age 19 or older.
- b) Dental services not listed as covered in this Booklet.
- c) Oral hygiene instructions.
- d) Case presentations.
- e) Athletic mouth guards, enamel microabrasion and odontoplasty.
- f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- h) Pulp vitality tests.
- i) Adjunctive diagnostic tests.
- j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.

- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
 - l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
 - m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
 - n) Incomplete root canals.
 - o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
 - p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - q) Provisional splinting, temporary procedures or interim stabilization.
 - r) Services of anesthesiologists, unless required by law.
 - s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
 - t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
 - u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
 - v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - w) Canal prep & fitting of preformed dowel & post.
 - x) Temporary, provisional or interim crown.
 - y) Occlusal procedures.
 - z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
 - aa) Pin retention is not covered when billed separately from restoration procedure.
 - bb) Services for the replacement of an existing partial denture with a bridge.
 - cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
 - dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
 - ee) Separate services billed when they are an inherent component of another covered service.
 - ff) Cone beam images.
 - gg) Anatomical crown exposure.
 - hh) Temporary anchorage devices.
 - ii) Sinus augmentation.
 - jj) Repair or replacement of lost/broken appliances.
- 16) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
- 17) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services,

whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the process and criteria we use to determine if a Service is Experimental or Investigational are outlined below.

- 18) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 19) **Eye Exercises** Orthoptics and vision therapy.
- 20) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 21) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 22) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
 - a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 23) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.
- 24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- 27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- 29) **Infertility Treatment** Testing or treatment related to infertility.
- 30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 31) **Medical Equipment and Supplies**

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
- 32) **Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- 33) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 34) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 35) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 36) **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Urgent Care, or Authorized Services.
- 37) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 38) **Personal Care and Convenience**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c) Home workout or therapy equipment, including treadmills and home gyms,
 - d) Pools, whirlpools, spas, or hydrotherapy equipment.
 - e) Hypo-allergenic pillows, mattresses, or waterbeds,
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- 39) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.
- 40) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.
- 41) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.
- 42) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 43) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.
- 44) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 45) **[Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]

- 46) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- 47) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 48) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 49) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 50) **Vision Services**
- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
 - b) Safety glasses and accompanying frames.
 - c) For two pairs of glasses in lieu of bifocals.
 - d) Plano lenses (lenses that have no refractive power)
 - e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
 - f) Vision services not listed as covered in this Booklet.
 - g) Cosmetic lenses or options.
 - h) Blended lenses.
 - i) Oversize lenses.
 - j) Sunglasses and accompanying frames.
 - k) For services or supplies combined with any other offer, coupon or in-store advertisement.
 - l) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
 - m) Certain frames in which the manufacturer imposes a no discount policy.
- 51) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
- This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- [Add if group chooses to cover Bariatric Surgery per mandate option** This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]
- 52) **Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgeries that reduce stomach size), or gastric banding procedures].

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

[Optional:

2. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your Physician believe you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE. We will cover your current Prescription Drug only if We agree that it is Medically Necessary and appropriate over its clinically equivalent alternative.]

3. **Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.

[Religious opt out to exclude Contraceptive Drugs:

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary).** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Physician believe you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments.
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.

15. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
16. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
18. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan. Details on the process and criteria your Plan uses to decide if a service is Experimental or Investigational are outlined below.

If you disagree with our denial of a service as Experimental or Investigational, you have the right to file a Grievance with us. Please refer the **Grievance and External Review Procedures** section of this Booklet for more information.

Process to Determine an Experimental or Investigational Service

Our process to decide whether a service is Experimental or Investigational includes medical and technical research of the service, committee review and decision, and final approval by our Chief Medical Officer.

First, our medical policy staff reviews a service based on the criteria listed in the provision below. Information on the service is gathered and combined by our Medical policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of our formal policy.

Next, the draft of the policy and literature on the service is distributed to the medical policy committee for review and discussion. The committee, which meets four times a year, is made up of a panel of Plan Physicians, most of which are actively practicing In-Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory organizations. The committee may also ask for input from one or more Physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the service, the committee recommends a final policy. The policy is forwarded to the medical policy committee chairman and Chief Medical Officer for approval.

Our policy on a service is reviewed as appropriate, every three years or less, by our medical policy staff and medical policy committee, with approval of our Chief Medical Officer and medical policy committee chairman.

We also maintain a process for deciding when existing policy on a service calls for added review and change and alerts our medical policy committee of the need to change the existing policy or make a new policy. This may come about as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change our position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by us to make policy change between regularly scheduled meetings of the medical policy committee.

Criteria to Determine an Experimental or Investigational Service

The criteria we or our designee use when making the determination of whether a Service is Experimental or Investigational when it is rendered for the evaluation or treatment of a disease, injury, illness or condition is outlined below. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Programs" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under this product are not covered except for Emergency Care, or when allowed as an Authorized Service by us. When you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency Care, or unless the services are approved by us as an Authorized Service.

For Covered Services You receive from an Out-of-Network Provider for Emergency Care or for services approved as an Authorized Service, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the

Provider will render. You will also need to know the Provider's charges to calculate your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

If you receive Covered Services in an In-Network Provider facility from an Out-of-Network Provider, such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with the In-Network Hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Care or Urgent Care services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a

Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("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.

Typically, when accessing care outside Anthem's Service Area and the Service Area of Anthem's corporate parent, 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 non-participating healthcare Providers. Anthem's payment practices in both instances are described below.

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care and urgent care obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your Primary Care Physician ("PCP").

BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area 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.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount, as stated in your Booklet.

Emergency Care Services: If you experience a Medical Emergency while traveling outside the Anthem Service Area, go to the nearest Emergency or Urgent Care Facility.

Whenever you access covered healthcare services outside Anthem's and, if applicable, Anthem's corporate parent's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special

arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. A Out-of-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 [(*carve-out*) Medicare,] 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 generally 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.

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.

"Recovery" means is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.

- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

Grievance and External Review Procedures

Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-800-368-3238] if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3 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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days

from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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.

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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and:
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- **[Domestic partner coverage: [This only applies to Groups who have this option:]]** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who **[Standard when affidavit used]** has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for [12 months] or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll [during an Open Enrollment period or] during a Special Enrollment period, as described below.

[Open Enrollment

Open Enrollment refers to a period of time, usually [60 days], during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Dependents:</u> A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits

Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

If we terminate the Group Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, we will continue your coverage for Inpatient Covered Services. Coverage will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after the Group Contract terminated;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by us;
- The Premium is not paid within the grace period shown in the Group Contract.

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Corporate Structure

The Plan is an Indiana domiciled insurance corporation owned by its stockholders and directed by a board of directors, who provide general leadership to the Plan. It is managed by a team of officers who receive direction from the board of directors and in turn direct the operations of the Plan. The Plan consists of a number of operational divisions including, but not limited to: Operations, Medical Management, Network Development, Marketing, Claims Administration, Risk Management, Legal and Member Services.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing

eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health

assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the “Schedule of Benefits” for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in “Benefits After Termination.”

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the “What’s Covered” section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Medical technology or a new application of existing medical technology, including medical procedures, Drugs, and devices for treating a medical condition, illness, or diagnosis that:

- is not generally accepted by informed health care professionals in the United States as effective; or

- has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

For how this is determined, see the “What’s Not Covered” section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient’s Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the “What’s Covered” section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Claims Payment” section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

[Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.]

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the

formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Predetermination

Please see the section “Getting Approval for Benefits ” for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 2) Insulin, diabetic supplies, and syringes.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

**Anthem Bronze Blue Preferred [on exchange only: X] POS 6000/30%/6600
Plus**



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

[on-exchange only: If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.]

Anthem Insurance Companies, Inc.

**[120 Monument Circle]
[Indianapolis, Indiana 46204]**

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, [www.anthem.com]. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, [www.anthem.com]

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:]

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a

federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

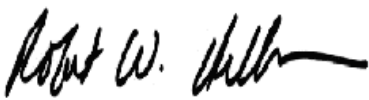

[President]

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] [off-exchange only: Plan Year]
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Deductible	In-Network	Out-of-Network
Per Member	\$6,000	\$12,000
Per Family - All other Members combined	\$12,000	\$24,000
The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.		

Coinsurance	In-Network	Out-of-Network
Plan Pays	70%	50%
Member Pays	30%	50%
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	\$6,600	\$13,200
Per Family – All other Members combined	\$13,200	\$26,400
The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services. The Out-of-Pocket Limit does not include amounts you pay for following benefits: • Out-of-Network Human Organ and Tissue Transplant services. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water)	30% Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan’s Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see “Getting Approval for Benefits” for details.		
Ambulance Services (Ground)	30% Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan’s Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see “Getting Approval for Benefits” for details.		
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	See “Mental Health and Substance Abuse Services.”	
Cardiac Rehabilitation	See “Therapy Services.”	
Chemotherapy	See “Therapy Services.”	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	
Dental Services Accidental Injury Benefit Maximum	\$3,000 per Accidental Injury In- and Out-of-Network combined	
Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that we are required to cover by law.		
Dental Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
Diagnostic and Preventive Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Basic Restorative Services	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dentally Necessary Orthodontic Care Waiting Period	12 Months	
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under “Preventive Care.”	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Dialysis	See “Therapy Services.”	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period In- and Out-of-Network combined	
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		
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, and Copayment as any other service under this Plan.		
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	\$250 Copayment per visit plus 30% Coinsurance after Deductible	
	Copayment waived if admitted	
Emergency Room Doctor Charge	30% Coinsurance after Deductible	
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	
Home Care		
Home Care Visits	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Dialysis	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Infusion Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Specialty Prescription Drugs	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Home Care Services / Supplies	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period In- and Out-of-Network combined	
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period In- and Out-of-Network combined	
	164 visits per Lifetime In- and Out-of-Network combined	
Home Infusion Therapy	See “Home Care.”	
Hospice Care		
- Home Care - Respite Hospital Stays	0% Coinsurance after Deductible	50% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility. Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission. Doctor Services for: - General Medical Care / Evaluation and Management (E&M) 30% Coinsurance after Deductible 50% Coinsurance after Deductible - Surgery 30% Coinsurance after Deductible 50% Coinsurance after Deductible		
Maternity and Reproductive Health Services - Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) 30% Coinsurance after Deductible 50% Coinsurance after Deductible If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately. - Inpatient Services (Delivery) See "Inpatient Services" Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services - Inpatient Facility Services \$500 Copayment per admission plus 30% Coinsurance after Deductible 50% Coinsurance after Deductible - Residential Treatment Center Services \$500 Copayment per admission plus 30% Coinsurance after Deductible 50% Coinsurance after Deductible - Inpatient Doctor Services 30% Coinsurance after Deductible 50% Coinsurance after Deductible - Outpatient Facility Services \$250 Copayment per visit plus 30% Coinsurance after Deductible 50% Coinsurance after Deductible		

Benefits	In-Network	Out-of-Network
Outpatient Doctor Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Office Visits	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” in the “Additional Federal Notices” section for details.		
Occupational Therapy	See “Therapy Services.”	
Office Visits		
Primary Care Physician / Provider (PCP)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Specialty Care Physician / Provider (SCP)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Retail Health Clinic Visit	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Online Visit	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Nutritional Counseling for Eating Disorders - Allergy Testing - Allergy Shots / Injections (other than allergy serum) - Preferred Diagnostic Labs (i.e., reference labs) - Diagnostic Lab (non-preventive) - Diagnostic X-ray (non-preventive) - Diagnostic Tests (non-preventive; including hearing and EKG) - Advanced Diagnostic Imaging (including MRIs, CAT scans) - Office Surgery - Therapy Services: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational Therapy - Dialysis / Hemodialysis - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Cardiac Rehabilitation & Pulmonary Therapy	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible \$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible \$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible \$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		

Benefits	In-Network	Out-of-Network
Prescription Drugs Administered in the Office (includes allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.		
Orthotics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	
Outpatient Facility Services		
Facility Surgery Charge	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Doctor Surgery Charges	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Lab	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic X-ray	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Therapy: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Dialysis / Hemodialysis - Cardiac Rehabilitation & Pulmonary Therapy See "Therapy Services" for details on Benefit Maximums. - Prescription Drugs Administered in an Outpatient Facility	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible
Physical Therapy	See "Therapy Services."	
Preventive Care	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Pulmonary Therapy	See "Therapy Services."	
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See "Therapy Services."	

Benefits	In-Network	Out-of-Network
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	See "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received.	
• [<i>optional offer mandate – add when selected</i> –Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime In- and Out-of-Network combined]	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services Benefit Maximum(s): • Physical Therapy • Occupational Therapy • Speech Therapy • Manipulation Therapy • Cardiac Rehabilitation Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit. Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.	Benefits are based on the setting in which Covered Services are received. Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined. 20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 36 visits per Benefit Period	
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	

Benefits	In-Network	Out-of-Network
Urgent Care Services (Office Visits)		
• Urgent Care Office Visit Charge	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Testing	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (other than allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (includes allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Vision Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
• Routine Eye Exam	\$0 Copayment	Covered up to \$30
Limited to one exam per Benefit Period		
• Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Covered up to \$25

Benefits	In-Network	Out-of-Network
Bifocal	\$0 Copayment	Covered up to \$40
Trifocal	\$0 Copayment	Covered up to \$55
Progressive	\$0 Copayment	Covered up to \$40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.		
Frames	\$0 Copayment	Covered up to \$45
Limited to one set of frames from the Anthem Formulary per Benefit Period.		
Contact Lenses		
Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		
Benefits are based on the setting in which Covered Services are received.		

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further details.)

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services, related to a Covered Transplant Procedure, that you get before or after the

Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of- Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
Precertification required	During the Transplant Benefit Period, no Copayment / Deductible / Coinsurance. Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	During the Transplant Benefit Period, You will pay 50% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for

		Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers No Copayment / Deductible / Coinsurance	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers 50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant In- and Out-of-Network combined	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant In- and Out-of-Network combined	

Live Donor Health Services	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Prescription Drug Deductible (waived for Tier 1)		
Per Member	\$250 In- and Out-of-Network combined	
Per Family	\$500 In- and Out-of-Network combined	
Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy (In-Network and Out-of-Network)	30 days*	
	*See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$15 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 2 Prescription Drugs	\$35 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 3 Prescription Drugs	\$70 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 4 Prescription Drugs	\$30% Coinsurance to a maximum of \$500 per Prescription Drug	50% Coinsurance per Prescription Drug
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$38 Copayment per Prescription Drug	Not Covered
Tier 2 Prescription Drugs	\$88 Copayment per Prescription Drug	Not Covered
Tier 3 Prescription Drugs	\$175 Copayment per Prescription Drug	Not Covered
Tier 4 Prescription Drugs	\$30% Coinsurance to a maximum of \$500 per Prescription Drug	Not Covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy. [Optional: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.]		

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits

In-Network

Out-of-Network

Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

Orally Administered Cancer Chemotherapy

No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In--Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.

No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-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.

How Your Plan Works

Introduction

Your Plan is a Point of Service (POS) plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at [\[www.anthem.com\]](http://www.anthem.com), which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Please note that not all In-Network Providers offer all services. For example, **when you need Outpatient lab services**, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

Service Area

The Service Area for this Plan is the State of Indiana.

[PC2 option:

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in our Service Area. If you are receiving care from an In-Network Provider whose contractual relationship with us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated In-Network Provider for a set period.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

[off exchange only: Crediting Prior Plan Coverage

If You were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then You will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If Your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and You were covered by the other product immediately before enrolling in this product with no break in coverage, then You may get credit for any accrued Deductible and Out-of-Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If Your Group offers more than one of our products, and You change from one product to another with no break in coverage, You will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If Your Group offers coverage through other products or carriers in addition to ours, and You change products or carriers to enroll in this product with no break in coverage, You will get credit for any accrued Deductible, Out-of-Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.]

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need Emergency or urgent care services, as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details. Please note that you only have coverage for Emergency and urgent care health care services when traveling outside the United States.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review (“requesting Provider”). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by a BlueCard/Out-of-Network/Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Request Categories

- **Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review-** A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an Inpatient admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
<i>Precertification Requests</i>	
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
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
<i>Predetermination Requests</i>	
Prospective Urgent	72 hours from the receipt of request
Prospective Non- Urgent	15 calendar days from the receipt of the request
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A morgue or funeral home.

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services**Endodontic Therapy on Primary Teeth**

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;

- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;

- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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: (a)

place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means 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.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor does not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

See “Therapy Services” later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant

Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,

- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.]

[Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the “Preventive Care” benefit.]

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,

- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the “Home Care” benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor’s Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.

Urgent Care as described in “Urgent Care Services” later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the “Diagnostic Services” benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women’s contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”]
 - b. Breastfeeding support, supplies, and counseling. [Standard Benefits for breast pumps are limited to [1-10 one] pump per [Standard pregnancy] [Benefit Period].]
 - c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites, [<http://www.healthcare.gov/center/regulations/prevention.html>,] [<http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.]

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” later in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members/All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.

- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services For Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In Network.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

Benefits do not include glasses or contact lenses except as listed in the “Prosthetics” benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- [Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at [www.anthem.com].]

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs. This tier contains higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the “Schedule of Benefits.” In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details.
- 2) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
- 3) **Administrative Charges**
 - a) Charges to complete claim forms,
 - b) Charges to get medical records or reports,
 - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - a. Acupuncture,
 - b. Holistic medicine,
 - c. Homeopathic medicine,
 - d. Hypnosis,
 - e. Aroma therapy,
 - f. Massage and massage therapy,
 - g. Reiki therapy,
 - h. Herbal, vitamin or dietary products or therapies,
 - i. Naturopathy,
 - j. Thermography,
 - k. Orthomolecular therapy,
 - l. Contact reflex analysis,
 - m. Bioenergetic synchronization technique (BEST),
 - n. Iridology-study of the iris,
 - o. Auditory integration therapy (AIT),
 - p. Colonic irrigation,
 - q. Magnetic innervation therapy,
 - r. Electromagnetic therapy.

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

15) Dental Services

- a) Dental care for Members age 19 or older.
- b) Dental services not listed as covered in this Booklet.
- c) Oral hygiene instructions.
- d) Case presentations.
- e) Athletic mouth guards, enamel microabrasion and odontoplasty.
- f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- h) Pulp vitality tests.
- i) Adjunctive diagnostic tests.
- j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.

- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
 - l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
 - m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
 - n) Incomplete root canals.
 - o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
 - p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - q) Provisional splinting, temporary procedures or interim stabilization.
 - r) Services of anesthesiologists, unless required by law.
 - s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
 - t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
 - u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
 - v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - w) Canal prep & fitting of preformed dowel & post.
 - x) Temporary, provisional or interim crown.
 - y) Occlusal procedures.
 - z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
 - aa) Pin retention is not covered when billed separately from restoration procedure.
 - bb) Services for the replacement of an existing partial denture with a bridge.
 - cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
 - dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
 - ee) Separate services billed when they are an inherent component of another covered service.
 - ff) Cone beam images.
 - gg) Anatomical crown exposure.
 - hh) Temporary anchorage devices.
 - ii) Sinus augmentation.
 - jj) Repair or replacement of lost/broken appliances.
- 16) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
- 17) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services,

whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the process and criteria we use to determine if a Service is Experimental or Investigational are outlined below.

- 18) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 19) **Eye Exercises** Orthoptics and vision therapy.
- 20) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 21) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 22) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
 - a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 23) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.
- 24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- 27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- 29) **Infertility Treatment** Testing or treatment related to infertility.
- 30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 31) **Medical Equipment and Supplies**

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
- 32) Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- 33) Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 34) Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 35) Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 36) Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 37) Personal Care and Convenience**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c) Home workout or therapy equipment, including treadmills and home gyms,
 - d) Pools, whirlpools, spas, or hydrotherapy equipment.
 - e) Hypo-allergenic pillows, mattresses, or waterbeds,
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- 38) Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.
- 39) Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.
- 40) Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.
- 41) Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 42) Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.
- 43) Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 44) [Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]
- 45) Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

- 46) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 47) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 48) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 49) **Vision Services**
- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
 - b) Safety glasses and accompanying frames.
 - c) For two pairs of glasses in lieu of bifocals.
 - d) Plano lenses (lenses that have no refractive power)
 - e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
 - f) Vision services not listed as covered in this Booklet.
 - g) Cosmetic lenses or options.
 - h) Blended lenses.
 - i) Oversize lenses.
 - j) Sunglasses and accompanying frames.
 - k) For services or supplies combined with any other offer, coupon or in-store advertisement.
 - l) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
 - m) Certain frames in which the manufacturer imposes a no discount policy.

- 50) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover Bariatric Surgery per mandate option] This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

- 51) **Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgeries that reduce stomach size), or gastric banding procedures].

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **[optional - Clinically-Equivalent Alternatives]** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs expected to produce similar therapeutic outcomes for a disease or

condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at [www.\[anthem\].com](http://www.[anthem].com).

If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over its clinically equivalent alternative.】

3. **Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.

[Religious group opt out to exclude Contraceptive drugs:

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.】
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com.】 If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments.
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
15. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.

16. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
18. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan. Details on the process and criteria your Plan uses to decide if a service is Experimental or Investigational are outlined below.

If you disagree with our denial of a service as Experimental or Investigational, you have the right to file a Grievance with us. Please refer the **Grievance and External Review Procedures** section of this Booklet for more information.

Process to Determine an Experimental or Investigational Service

Our process to decide whether a service is Experimental or Investigational includes medical and technical research of the service, committee review and decision, and final approval by our Chief Medical Officer.

First, our medical policy staff reviews a service based on the criteria listed in the provision below. Information on the service is gathered and combined by our Medical policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of our formal policy.

Next, the draft of the policy and literature on the service is distributed to the medical policy committee for review and discussion. The committee, which meets four times a year, is made up of a panel of Plan Physicians, most of which are actively practicing In-Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory organizations. The committee may also ask for input from one or more Physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the service, the committee recommends a final policy. The policy is forwarded to the medical policy committee chairman and Chief Medical Officer for approval.

Our policy on a service is reviewed as appropriate, every three years or less, by our medical policy staff and medical policy committee, with approval of our Chief Medical Officer and medical policy committee chairman.

We also maintain a process for deciding when existing policy on a service calls for added review and change and alerts our medical policy committee of the need to change the existing policy or make a new policy. This may come about as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change our position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by us to make policy change between regularly scheduled meetings of the medical policy committee.

Criteria to Determine an Experimental or Investigational Service

The criteria we or our designee use when making the determination of whether a Service is Experimental or Investigational when it is rendered for the evaluation or treatment of a disease, injury, illness or condition is outlined below. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Programs" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket

responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total out of pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*
- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of*

\$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.

- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of \$1500, or \$450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is \$500, you may receive a bill from the Out-of-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your In-Network Copayment of \$25, your total out of pocket expense would be \$325.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

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.

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency and urgent care obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

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, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Anthem serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Booklet.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When covered healthcare services are provided outside of our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. A Out-of-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 [(carve-out) Medicare,] 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 generally 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.

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.

“Recovery” means is money you receive from another, their insurer or from any “Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.

- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to [anthem.com](https://www.anthem.com) and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

Grievance and External Review Procedures

Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-800-368-3238] if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3 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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days

from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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.

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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and:
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

The Subscriber's spouse. For information on spousal eligibility please contact the Group.

- **[Domestic partner coverage option:[This only applies to Groups who have this option:]]** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who **[Standard when affidavit used]** has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for [12 months] or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during [an Open Enrollment period or during] a Special Enrollment period, as described below.

[Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Dependents:</u> A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits

Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

If we terminate the Group Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, we will continue your coverage for Inpatient Covered Services. Coverage will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after the Group Contract terminated;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by us;
- The Premium is not paid within the grace period shown in the Group Contract.

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Corporate Structure

The Plan is an Indiana domiciled insurance corporation owned by its stockholders and directed by a board of directors, who provide general leadership to the Plan. It is managed by a team of officers who receive direction from the board of directors and in turn direct the operations of the Plan. The Plan consists of a number of operational divisions including, but not limited to: Operations, Medical Management, Network Development, Marketing, Claims Administration, Risk Management, Legal and Member Services.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing

eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.]

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health

assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the “Schedule of Benefits” for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in “Benefits After Termination.”

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the “What’s Covered” section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Medical technology or a new application of existing medical technology, including medical procedures, Drugs, and devices for treating a medical condition, illness, or diagnosis that:

- is not generally accepted by informed health care professionals in the United States as effective; or

- has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

For how this is determined, see the “What’s Not Covered” section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient’s Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the “What’s Covered” section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Claims Payment” section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the

formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Predetermination

Please see the section “Getting Approval for Benefits ” for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 2) Insulin, diabetic supplies, and syringes.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

SERFF Tracking #:	AWLP-129529740	State Tracking #:	ABCBS-SG HMO ON/OFF EXCH-V02	Company Tracking #:	
State:	Indiana	Filing Company:	Anthem Insurance Companies, Inc.		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	IN 2015 - On- and Off-Exchange - SG				
Project Name/Number:	/				

Rate Information

Rate data applies to filing.

Filing Method:	File and Approve
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	2.860%
Effective Date of Last Rate Revision:	10/01/2014
Filing Method of Last Filing:	File and Approve

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Anthem Insurance Companies, Inc.	Increase	3.530%	3.530%	\$7,024,187	1,032	\$199,088,770	16.800%	-1.800%

SERFF Tracking #: AWLP-129529740

State Tracking #: ABCBS-SG HMO ON/OFF
EXCH-V02

Company Tracking #:

State: Indiana

Filing Company: Anthem Insurance Companies, Inc.

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name: IN 2015 - On- and Off-Exchange - SG

Project Name/Number: /

Rate Review Detail

COMPANY:

Company Name: Anthem Insurance Companies, Inc.

HHS Issuer Id: 17575

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
HMO/POS On-Exchange, HMO/POS Off-Exchange, PPO Off-Exchange		17575-62750	10729

Trend Factors:

FORMS:

New Policy Forms: ABCBS-SG HMO ON/OFF EXCH-v02, ABCBS-SG POS ON/OFF EXCH-v02, ABCBS-SG PPO OFF EXCH-v02

Affected Forms:

Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual

Member Months: 413,990

Benefit Change: Increase

Percent Change Requested: Min: -1.8 Max: 16.8 Avg: 3.5

PRIOR RATE:

Total Earned Premium: 199,088,770.00

Total Incurred Claims: 151,544,656.00

Annual \$: Min: 213.80 Max: 1,978.44 Avg: 480.90

REQUESTED RATE:

Projected Earned Premium: 206,112,957.00

Projected Incurred Claims: 154,154,146.00

Annual \$: Min: 120.96 Max: 1,291.98 Avg: 497.87

SERFF Tracking #:

AWLP-129529740

State Tracking #:

ABCBS-SG HMO ON/OFF EXCH-V02

Company Tracking #:

State:

Indiana

Filing Company:

Anthem Insurance Companies, Inc.

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name:

IN 2015 - On- and Off-Exchange - SG

Project Name/Number:

/

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Response to 5/29 Objection		Other	Previous State Filing Number: Rate Action Other Explanation:	SG response to objection 05_29_14.pdf, Early Renewal Impact.pdf, Experience to Rating Morbidity.pdf,
2		Response to 6/12 Objection		Other	Previous State Filing Number: Rate Action Other Explanation:	Major_Medical_Experience_Workbook - 2015 SG ACA.xlsx,

SERFF Tracking #:	AWLP-129529740	State Tracking #:	ABCBS-SG HMO ON/OFF EXCH-V02	Company Tracking #:	
State:	Indiana	Filing Company:	Anthem Insurance Companies, Inc.		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	IN 2015 - On- and Off-Exchange - SG				
Project Name/Number:	/				

Attachment Major_Medical_Experience_Workbook - 2015 SG ACA.xlsx is not a PDF document and cannot be reproduced here.

Thank you for your inquiry dated 5/29/14.

- 1) *There is a small difference in the incurred claims and member months shown on the URRT vs. what is shown in Exhibit B though they cover the same incurred period. Please explain the reason for the discrepancy.*

The URRT experience is only for the Single Risk Pool, so it does not include grandfathered business, but does include (non-plan sponsored) association business. The experience shown in Exhibit B was used in our rate development, which is our Indiana Small Group block of business, including grandfathered business, but excludes association business.

- 2) *The 11.2% trend assumption is very high compared to what we see from other carriers. Please provide more detail on the methodology used to develop this trend rate. We would prefer to see some numbers behind this assumption if at all possible. A summarized exhibit would be sufficient.*

The pricing trend used in the development of the rates was 11.2%. Our normalized claims trend during this rating period is 8.9%. The assumption used for selection and provision for adverse deviation is approximately 2.3%.

The normalized claims trend is developed by an actuarial normalization process. The process normalizes historical net benefit expense for changes in the underlying population and known cost drivers such as age/gender, provider contracting, and benefits. The resulting normalized claims trend is projected forward from the experience period to the rating period. Cost drivers not already included elsewhere in the rate development (e.g., provider contracting) are then combined with the normalized trend to calculate the pricing trend.

- 3) *The member months, incurred claims and premiums shown in the Rate Review Detail page are much lower than what is shown in the URRT. If this is correct, please help us to reconcile the two sets of numbers.*

The member months, incurred claims and premiums shown in the Rate Review Detail page under "Requested Rate" illustrates our projected 2015 ACA block of business. The corresponding numbers in the URRT represent the 2013 Indiana Small Group Single Risk Pool Non-Grandfathered block of business.

The projected member months in the URRT (413,987) matches the member months in the Rate Review Detail page (413,990). The difference is due to rounding required in the URRT.

- 4) *Please provide a Medical Experience Workbook.*

I spoke to Karl Knable concerning the Major Medical Experience Workbook. He suggested the Workbook was not necessary for the 2015 ACA rate filings and that the experience in the URRT was sufficient for review of this filing. Please let me know if there are any further concerns regarding this request.

- 5) *Thank you for the discussion of morbidity and the various population movements. Could you please provide more detail on the 1.0643 factor used? We would like to see a little more detail as to how that was derived and the components of that factor.*

The 6.43% referenced above consists of 0.66% for population changes, 7.51% for the impact of the early renewal, -1.26% for experience to rating morbidity, and -0.40% for uninsured excess morbidity.

Population Changes – 0.66%

This impact captures the expected morbidity change from members leaving the Small Group cohort. It mostly reflects the expectation that healthier groups will leave and get coverage elsewhere assuming it will be a better deal for them to do so. This adjustment decreased significantly from 2014 (1.44%) to 2015 (0.66%) because we lowered our assumption regarding the volume of members that would leave the Small Group market.

Early Renewal Impact – 7.51%

Please see “Early Renewal Impact.pdf” included with this response that provides additional detail related to the Early Renewal Impact.

Experience to Rating Morbidity – -1.26%

Please see “Experience to Rating Morbidity.pdf” included with this response that provides additional detail related to the Experience to Rating Morbidity.

Uninsured Excess Morbidity – -0.40%

Uninsured Excess Morbidity relates to the additional morbidity expected from the Uninsured market moving to the Individual market. For Small Group, this component captures the favorable adjustment we expect to see because of the decline in COBRA membership in the group market from 2013 to 2015.

Small Group projected claims for 2015 pricing were based on 2013 Small Group claims experience. The claims for Small Group members who have elected to continue health coverage under COBRA are included in the 2013 Small Group claims experience. Small Group COBRA members have much higher morbidity than non-COBRA members and inclusion of COBRA members in the experience increases the average morbidity of the Small Group cohort.

COBRA members will continue to be included in the Small Group segment in 2015, but we expect a significant decline in COBRA penetration from 2013 to 2015. The Small Group COBRA Morbidity Adjustment captures the morbidity impact of the decrease in COBRA penetration from the experience period to the rating period.

COBRA Morbidity Adjustment Calculation Description:

Based on internal COBRA claims experience, we estimated that the COBRA morbidity is 2.35 times the non-COBRA morbidity. Using this assumption the morbidity impact was calculated as the expected Health Status (HS) of the Total Small Group population using the 2015 COBRA penetration assumption divided by the expected HS of the Total Small Group population using the 2013 COBRA penetration rate:

$$[(1-2015 \text{ COBRA Penetration}) * \text{Non-COBRA HS} + 2015 \text{ COBRA Penetration} * 2.35 * \text{Non-COBRA HS}]$$

$$[(1-2013 \text{ COBRA Penetration}) * \text{Non-COBRA HS} + 2013 \text{ COBRA Penetration} * 2.35 * \text{Non-COBRA HS}]$$

$$= [(1-0.002) + 0.002 * 2.35] / [(1-0.005) + 0.005 * 2.35] = 0.9960$$

Indiana Small Group Early Renewal (Transition Policy) Load

Balanced ACA Risk Pool

<u>Block of Business</u>	<u>% of Market</u>	<u>Avg Prem Relativity</u>
ACA	100%	1.000

Notes

Baseline scenario where transition policies do not exist.

Starting morbidity assumptions based on this scenario, where ACA risk pool is balanced.

Breakdown of Expected Group Selection

	<u>% of Market</u>	<u>Avg Prem Relativity</u>
Transition Policies	55.5%	0.894 (at ACA rate levels)
ACA Policies	44.5%	1.133
	100.0%	1.000

Notes

Groups identified as likely transition policies based on current early renewal status and projected rate disruption moving to ACA.

Avg Prem Relativities based on ACA rates.

Avg Prem Relativity should remain 1.000 for entire book, since 1.000 is based on appropriate rate level for entire block.

With Transition Policies

	<u>% of Market</u>	<u>Avg Prem Relativity</u>
Transition Policies	55.5%	0.826
ACA Policies	44.5%	1.218
	100.0%	1.000

Required Early Renewal (Transition) Load

1.0751

Notes

Transition Policies cohort based on same members and same benefits, but rate levels lower for pre-ACA (.826 vs. .894).

Early renewal load is required to keep same overall premium level (normalized for same benefits).

Transition policies have lower pre-ACA premium due to increased selection of transition policies by younger, healthier groups.

IN Small Group Wakely Adjustment

Participation

# carriers	6
Participating Market Share	83%
Anthem Market Share	55%

Anthem Relative Risk for 2013

<u>Carrier</u>	<u>Market Share</u>	<u>Relative Risk*</u>
Anthem	55.0%	1.01305
Market	83.0%	1.0000

* Relative Risk is based on HHS risk adjustment methodology, which normalizes for allowable rating factors.

Adjustment to Market Premium / Final Adjustment

Anthem Premium vs. Market Leaders	+10%
Adjustment from Anthem to Market Premium*	0.965
Anthem Relative Risk (expected transfers)	0.0131
Expected Transfers at Market Premium	0.0126
Final Experience to Rating Period Adjustment	0.9874

* Risk adjustment is based on market premium. If Anthem maintains relative risk position, Anthem would not be fully reimbursed at Anthem premium levels.

SERFF Tracking #:	AWLP-129529740	State Tracking #:	ABCBS-SG HMO ON/OFF EXCH-V02	Company Tracking #:	
State:	Indiana	Filing Company:	Anthem Insurance Companies, Inc.		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	IN 2015 - On- and Off-Exchange - SG				
Project Name/Number:	/				

Supporting Document Schedules

Bypassed - Item:	20 Small Group Checklist (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	20(C) Out of State Association/Trust Products Checklist (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	20(A) Small Group Checklist (Accident & Health)
Comments:	
Attachment(s):	22A_Small_Group_HMO_Checklist 2015.pdf 20A_Small_Group_Checklist 042914.pdf
Item Status:	
Status Date:	

Satisfied - Item:	4.2 Small Group New Rate/Form Requirements (Accident & Health)
Comments:	We acknowledge that we have read and understand the Small Group filing requirements.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	8.0 Small Group Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	4.2(A) QHP Small Group New Rate/Form Requirements (Accident & Health)
Comments:	We acknowledge that we have read and understand the Small Group QHP filing requirements.
Attachment(s):	
Item Status:	

State:	Indiana	Filing Company:	Anthem Insurance Companies, Inc.
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other		
Product Name:	IN 2015 - On- and Off-Exchange - SG		
Project Name/Number:	/		

Status Date:	
Bypassed - Item:	8.0(A) QHP Small Group Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	4.2(B) EHB Small Group New Rate/Form Requirements (Accident & Health)
Comments:	We acknowledge that we have read and understand the Small Group EHB filing requirements.
Attachment(s):	
Item Status:	
Status Date:	
Bypassed - Item:	8.0(B) EHB Small Group Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	09 SERFF Data Field Guide (Accident & Health)
Comments:	N/A
Attachment(s):	
Item Status:	
Status Date:	
Bypassed - Item:	03 PPACA Uniform Compliance Summary
Bypass Reason:	It is our opinion that this form isn't necessary because it has not been updated since fall 2010 with the initial PPACA requirements. Plus, some of the items are now moot like pre-x since it has to be removed altogether 1/2014. The state checklists are more current and cover all the necessary requirements for PPACA compliance.
Attachment(s):	
Item Status:	
Status Date:	
Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	note says that this must be bypassed initially
Attachment(s):	
Item Status:	

State:	Indiana	Filing Company:	Anthem Insurance Companies, Inc.
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other		
Product Name:	IN 2015 - On- and Off-Exchange - SG		
Project Name/Number:	/		

Status Date:	
Bypassed - Item:	04 Major Medical Experience Workbook (Accident & Health)
Bypass Reason:	Not required with this year's ACA filing.
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	IN SG Act_Memo_Output 5.9.14.pdf
Item Status:	
Status Date:	
Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	Will send to the IDOI Compliance email address concurrently.
Attachment(s):	
Item Status:	
Status Date:	
Satisfied - Item:	Redline Certificates of Coverage
Comments:	Attached are redline versions of our small group HMO, POS & PPO reflecting changes we made to the versions approved in 2014
Attachment(s):	Indiana SG ABCBS SG PPO OFF EXCH v02 redline.pdf Indiana ABCBS-SG HMO-ON-OFF EXCH-v02 redline.pdf Indiana SG ABCBS-SG POS-ON-OFF EXCH v02 redline.pdf
Item Status:	
Status Date:	
Satisfied - Item:	Certificate of Coverage Statements of Variability
Comments:	
Attachment(s):	IN HMO ON EXCH Statement of Variability.pdf IN POS ON EXCH Statement of Variability.pdf IN PPO OFF EXCH Statement of Variability 2015.pdf
Item Status:	
Status Date:	
Satisfied - Item:	EHB Crosswalk Tools & EHB Verification Template

State:	Indiana	Filing Company:	Anthem Insurance Companies, Inc.
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other		
Product Name:	IN 2015 - On- and Off-Exchange - SG		
Project Name/Number:	/		

Comments:	Please note both on & off exchange HMO & POS are QHPs. Only our PPO is exclusively offered off the exchange. Thus we only included the EHB Verification template for the off exchange PPO plans.
Attachment(s):	EHB_Crosswalk_Tool HMO.pdf EHB_Crosswalk_Tool POS.pdf EHB_Crosswalk_Tool PPO.pdf IN_EHB_Template PPO off SG.xlsx
Item Status:	
Status Date:	

Satisfied - Item:	Screenshots
Comments:	
Attachment(s):	Screenshots_17575IN072_17575IN073 - SG On-Exchange.pdf Screenshots_17575IN074 - SG Off-Exchange.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	AWLP-129529740	State Tracking #:	ABCBS-SG HMO ON/OFF EXCH-V02	Company Tracking #:	
State:	Indiana	Filing Company:	Anthem Insurance Companies, Inc.		
TOI/Sub-TOI:	H16G Group Health - Major Medical/H16G.003G Small Group Only - Other				
Product Name:	IN 2015 - On- and Off-Exchange - SG				
Project Name/Number:	/				

Attachment IN_EHB_Template PPO off SG.xlsx is not a PDF document and cannot be reproduced here.

**Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards**

**22(A) Non-Grandfathered
HMO Small Group Major Medical & Dental
HMO Small Business Health Option Program (SHOP) Major Medical and Dental**

This checklist must be submitted with any form filings for HMO Small Group Major Medical or Small Group Dental plans that are not Grandfathered. This checklist should also be used for Small Group Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for SHOP Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name _____ NAIC # _____

Form number(s) _____ Filing date _____

Product Type: ☐ Major Medical ☐ Pediatric Stand-Alone Dental

Exchange Participation: ☐ Off-Exchange ☐ On-Exchange

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

Contents

A. General Filing Requirements	2
B. Required Provisions.....	4
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D. Group A&H Policies <i>must offer</i>.....	9
E. General Regulatory Issues	9
F. ACA Must Provide.....	10
G. Specific Requirements for Qualified Health Plans in SHOP	24
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	26

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	FILING FEES: The fees are \$35 per form plus \$35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.		
IC 27-8-5-1(c)	TEMPLATE: Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates.htm		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	RATE FILING REQUIREMENTS: 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.		
Bulletin 125	FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL: Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.		
Bulletin 125	CONSULTING AUTHORIZATION: If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.		
Bulletin 125	ACKNOWLEDGEMENT: All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. <i>Please acknowledge.</i>		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL: Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.		
B. Required Provisions	The following rights of Insurers and insureds must be disclosed in group accident and sickness policies issued in Indiana. Exact wording is not required, as long as the substance matches the statutory language, or is more favorable to the insured or policyholder.		
IC 27-13-7-3(a)(1)	THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION		
IC 27-13-7-3(a)(2)	ELIGIBILITY REQUIREMENTS		
IC 27-13-7-3(a)(3)	BENEFITS AND SERVICES WITHIN THE SERVICE AREA		
IC 27-13-7-3(a)(4) IC 27-13-36-9	EMERGENCY CARE BENEFITS AND SERVICES		
IC 27-13-7-3(a)(5)	ANY OUT-OF-AREA BENEFITS AND SERVICES		
IC 27-13-7-3(a)(6)	COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS		
IC 27-13-7-3(a)(7)	LIMITATIONS AND EXCLUSIONS		
IC 27-13-7-3(a)(8)	ENROLLEE TERMINATION PROVISIONS		
IC 27-13-7-3(a)(9)	ANY ENROLLEE REINSTATEMENT PROVISIONS		
IC 27-13-7-3(a)(10)	CLAIMS PROCEDURES		
IC 27-13-36.2	CLEAN CLAIMS		
IC 27-13-7-3(a)(11)	ENROLLEE GRIEVANCE PROCEDURES		
IC 27-13-7-3(a)(12)	CONTINUATION OF COVERAGE PROVISIONS		
IC 27-13-7-3(a)(13)	CONVERSION PROVISIONS		
IC 27-13-7-3(a)(14)	EXTENSION OF BENEFIT PROVISIONS		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	COORDINATION OF BENEFIT PROVISIONS: Not applicable for Limited Service Health Maintenance Organizations		
IC 27-13-7-3(a)(16)	ANY SUBROGATION PROVISIONS		
IC 27-13-7-3(a)(17)	A DESCRIPTION OF THE SERVICE AREA		
IC 27-13-7-3(a)(18)	THE ENTIRE CONTRACT PROVISIONS		
IC 27-13-7-3(a)(19)	THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT		
IC 27-13-7-3(a)(20)	ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER		
IC 27-13-7-3(a)(21)	RIGHT OF RENEWAL PROVISIONS		
IC 27-13-7-3(a)(22)	PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER		
IC 27-13-7-3(a)(23)	GRACE PERIOD PROVISIONS		
IC 27-13-7-3(a)(24)	A PROVISION ON CONFORMITY WITH STATE LAW		
IC 27-13-7-3(a)(25)	GUARANTEED RENEWABILITY: A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	DEPENDENT AGE 26: A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.		
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	GRIEVANCE AND APPEALS PROCEDURE: Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier. Not applicable for Limited Service Health Maintenance Organizations per IC 27-13-34-12(4).		
BULLETIN 128	NOTICE to policyholders regarding filing complaints with the department of insurance		
C. HMO Group A&H Must Provide			
IC 27-8-5-15.6(e)	SUBSTANCE ABUSE PARITY —When abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits.		
IC 27-8-5-19(c)(17)	HANDICAPPED CHILDREN Beyond the age of maturity. (with 120 days notice of the company)		
IC 27-8-5-21	ADOPTED CHILDREN		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5.6-2(b)	NEWBORNS, UNLESS PREGNANCY PRE-EXISTED ISSUANCE OF POLICY		
IC 27-8-14.5	DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION		
IC 27-13-7-19	ORTHOTIC AND PROSTHETIC DEVICES		
IC 27-8-15-31	CONVERSION RIGHT		
IC 27-8-20	OFF-LABEL USE OF CERTAIN DRUGS, IF DRUGS ARE COVERED		
IC 27-8-24	MINIMUM MATERNITY STAYS, IF MATERNITY BENEFITS OFFERED		
IC 27-8-24.3	VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE		
IC 27-8-24-4	INFANT SCREENING TESTS required by IC 16-41-17-2		
IC 27-8-26	Individuals without regard to GENETIC TESTING		
IC 27-13-7-13	CONTINUATION OF COVERAGE STATEMENT		
IC 27-13-7-14	POST-MASTECTOMY BREAST RECONSTRUCTION & PROSTHESIS IF mastectomy coverage is provided regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	AUTISM SPECTRUM DISORDER (PREVIOUSLY PDD): As Per Bulletins 136 and 179, "Coverage for services will be provided as prescribed by the insured's treating physician in accordance with a treatment plan." Autism Spectrum Disorders include Asperger's Syndrome and Autism.		
IC 27-13-7-14.8	MENTAL HEALTH PARITY if mental health benefits provided		
IC 27-13-7-15	DENTAL ANESTHESIA/HOSPITALIZATION		
IC 27-8-14-6	MAMMOGRAPHY (Baseline, then 1 per year after 40 unless high risk) Due to the EHB Benchmark requirements, mammography <u>must</u> be covered.		
IC 27-8-14.7	PROSTATE CANCER SCREENING (1 per year after 50 unless high risk) Due to the EHB Benchmark requirements, prostate cancer screening <u>must</u> be covered.		
IC 27-13-7-18	INHERITED METABOLIC DISEASE		
IC 27-13-37.5-2	PRESCRIPTION DRUG: Can't require use of specific mail order pharmacy for coverage		
IC 27-13-38-1	PRESCRIPTION DRUG: Allows formularies but requires process for obtaining non-formulary drug		
Bulletin 172	CHEMOTHERAPY PARITY		
760 IAC 1-39-7	AIDS, HIV AND RELATED CONDITIONS IF other diseases covered (can't be unique exclusion) (Does not apply to specified disease policies)		
IC 27-8-14.8	COLORECTAL CANCER SCREENING Due to the EHB Benchmark requirements, colorectal cancer screening <u>must</u> be covered.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
D. Group A&H Policies must offer			
IC 27-8-14.1	MORBID OBESITY: Coverage for the surgical treatment of morbid obesity. For groups that choose to offer this benefit on the exchange, any premium related to this benefit would not be eligible for premium tax credit.		
E. General Regulatory Issues	Under the authority provided by IC 27-4-1-4, 27-8-5-1 and 27-8-5-1.5, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will also be reviewed.		
IC 27-13-7-2	APPLICATION QUESTIONS: 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.		
IC 27-13-7-2	ARBITRATION: Mandatory and/or binding arbitration provisions are prohibited.		
IC 27-13-7-2	LARGE ENDORSEMENTS: The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be re-filed to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.		
IC 27-13-7-2	OPEN ENDORSEMENTS: Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.		
IC 27-13-7-2	PROHIBITED PROVISIONS: The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	PRIVACY OF HEALTH INFORMATION: Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have regarding an individual's health condition.		
IC 27-13-7-2	VARIOUS FEES: Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.		
IC 27-8-5-2.5 IC 27-8-5-19(c)(6) IC 27-8-15-27	FIRST MANIFEST LANGUAGE: Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.		
Bulletin 103	FULL AND FINAL DISCRETION: No full and final discretion clauses except where policy is governed by ERISA.		
Bulletin 106	FOREIGN LANGUAGE FORMS: Foreign language forms must comply with Bulletin 106.		
F. ACA Must Provide	All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – AMBULATORY PATIENT SERVICES ACA §1302		
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – EMERGENCY SERVICES ACA §1302		
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – HOSPITALIZATION ACA §1302		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – MATERNITY AND NEWBORN CARE Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302		
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT ACA §1302		
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – PRESCRIPTION DRUGS ACA §1302		
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302		
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – LABORATORY SERVICES ACA §1302		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130		
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE Insurer must indicate if Pediatric dental services are being included and excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302		
IC 27-8-5-1(c)	LIMITATIONS ON ESSENTIAL HEALTH BENEFITS: The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS <i>Please acknowledge</i> PHSA §2711 75 Fed Reg 37188 45 CFR §147.126		
IC 27-8-5-1(c)	MATERIAL MODIFICATIONS Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits <i>Please acknowledge</i> PHSA §2715 75 Fed Reg 41760		
IC 27-8-5-1(c)	COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW") Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections <i>Please acknowledge</i> PHSA §2728 45 CFR §147.145		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). <i>Please acknowledge</i> 45 CFR §156.122(a)		
IC 27-8-5-1(c)	SUMMARY OF BENEFITS COVERAGE: The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. <i>Please acknowledge</i> PHSA §2715		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	NO PRE-EXISTING CONDITION EXCLUSIONS: A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage. <i>Please acknowledge</i> PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108		
IC 27-8-5-1(c)	MARKETING: Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(e)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	PROHIBITION ON DISCRIMINATION: The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125		
IC 27-8-5-1(c)	GUARANTEED AVAILABILITY OF COVERAGE: Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	OPEN ENROLLMENT: Insurer must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. Insurer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules defined in the Affordable Care Act and pursuant to applicable state law. If the plan is offered in SHOP, coverage must be effective consistent with the dates mandated by the SHOP Exchange even if plan is off Exchange. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(b)		
IC 27-8-5-1(c)	SPECIAL ENROLLMENT: Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 30 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(b) 45 CFR §155.410		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	SPECIAL RULES FOR NETWORK PLANS: (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.104(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	APPLICATION OF FINANCIAL CAPACITY LIMITS: Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(d)		
IC 27-8-5-1(c)	GUARANTEED RENEWABILITY OF COVERAGE: Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.106(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS: Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)		
IC 27-8-5-1(c)	DISCONTINUING PRODUCTS: Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.106(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	DISCONTINUING ALL COVERAGE: Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.106(d)		
IC 27-8-5-1(c)	UNIFORM MODIFICATION OF COVERAGE: Insurer may only modify coverage at the time of coverage renewal. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(e)		
IC 27-8-5-1(c)	COVERAGE THROUGH ASSOCIATIONS: Any reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)		
IC 27-8-5-1(c)	CLINICALLY APPROPRIATE DRUGS: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	EMERGENCY DEPARTMENT SERVICES: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	CATASTROPHIC PLANS: If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans in SHOP	Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated. All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)		
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)		
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)		
	PARTICIPATION RULES: Insurers offering a QHP through the SHOP may impose group participation rules for the offering of health insurance coverage in connection with a QHP 45 CFR §156.285 (e)		
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)		
	WAITING PERIODS: Group health plans may not impose waiting periods in excess of 90 days from the date on which an employee would be otherwise eligible for participation in the group health plan. Any special enrollment for newly eligible employees would occur at the expiration of any waiting period. PHSA §2708		
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify policy holder to contact the FFM for any changes to their eligibility determination. <i>Please acknowledge</i> 45 CFR §155.330		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated. All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, <u>either on or off the Exchange</u>. This type of plan has an effective date on or after January 1, 2014.		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.		

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

**Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards**

**20(A) Non-Grandfathered
Small Group Major Medical & Dental
Small Business Health Option Program (SHOP) Major Medical and Dental**

This checklist must be submitted with any form filings for Small Group Major Medical or Small Group Dental plans that are not Grandfathered. This checklist should also be used for Small Group Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for SHOP Exchange participation. This checklist should not be used for HMO plans.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name _____ NAIC # _____

Form number(s) _____ Filing date _____

Product Type: ☐ Major Medical ☐ Pediatric Stand-Alone Dental

Exchange Participation: ☐ Off-Exchange ☐ On-Exchange

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

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Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address each checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	FILING FEES: The fees are \$35 per form plus \$35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	TEMPLATE: Complete the data templates via SERFF: For Form Filings Only - Plans and Benefits Template For Rates and Forms Filing - Administrative Data - Essential Community Providers - Plans and Benefit - Prescription Drug - Network - Service Area - Rates - Business Rules - Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm		
Bulletin 125	RATE FILING REQUIREMENTS: - All new product filings must include rates - Any form filing that impacts rates must be accompanied by the related rate justification - If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.		
Bulletin 125	FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL: Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	CONSULTING AUTHORIZATION: If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.		
Bulletin 125	ACKNOWLEDGEMENT: All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. <i>Please acknowledge.</i>		
Bulletin 125	ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL: Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.		
B. Required Provisions	The following rights of Insurers and insureds must be disclosed in group accident and sickness policies issued in Indiana. Exact wording is not required, as long as the substance matches the statutory language, or is more favorable to the insured or policyholder.		
IC 27-8-5-19(c)(1)	GRACE PERIOD: The policyholder has a grace period of 31 days for payment of premium due, except the first premium. Policy remains in force during the grace period, but Insurer may hold claims incurred during grace period until premium is received.		
IC 27-8-5-19(c)(2)	INCONTESTABILITY: Validity of policy may not be contested after 2 years except for a) nonpayment of premiums, or if b) the disputed statement is in a written instrument signed by insured. Ineligibility of insured or enrollee under the policy may be disputed any time.		
IC 27-8-5-19(c)(3)	COPY OF APPLICATION: If there is an application, a copy must be attached to the policy at issue. Statements made by persons insured are representations, not warranties, and must be provided to insured persons in case of a dispute.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-19(c)(7)	MISSTATEMENT OF AGE: Clear statement of how premiums, benefits or both will be fairly adjusted if covered person's age is misstated and if premiums and benefits vary by age.		
IC 27-8-5-19(c)(8)	CERTIFICATE: Insurer must issue to policyholder, for delivery to each insured person, a certificate of coverage explaining the protection, to whom the benefits are payable, and each family member and dependent's coverage. (See below for debtor's certificate.)		
IC 27-8-5-19(c)(9)	TIMELY NOTICE OF CLAIM: Insured must provide written notice of claim within 20 days after occurrence or commencement of loss, or as soon as reasonably possible.		
IC 27-8-5-19(c)(10)	CLAIM FORMS: Insurer must provide forms for filing proof of loss within 15 days of notice of claim, or claimants can submit their own.		
IC 27-8-5-19(c)(11)	PROOF OF LOSS: Written proof must be furnished within 90 days of loss. Claim will not be reduced if proof was not reasonably possible but no later than 1 year after requirement.		
IC 27-8-5-19(c)(12) IC 27-8-5-3(a)(8) IC 27-8-5.7	TIME OF PAYMENT OF CLAIMS: Payment for any loss (other than loss for which the policy provides periodic payment) will be paid immediately upon receipt of due written proof of loss, OR an insurer shall pay or deny each clean claim or notify the claimant of any deficiencies within 30 days if the claim is filed electronically or within 45 days if the claim is filed on paper, whichever is more favorable to the policyholder. If a policy provides for a periodic payment, it will not be paid less frequently than monthly. Any balance remaining unpaid upon the termination of liability when the policy provides periodic payment will be paid immediately upon receipt of due written proof.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-19(c)(13)	BENEFICIARIES: Loss of life benefits are paid to the beneficiary designated by the insured. If the policy contains conditions pertaining to family status the policy terms apply. All other benefits payable to the person insured. Insurer may also choose to pay up to \$5000 to a relative by blood or marriage if beneficiary is an estate or a minor. (Does not apply to policies insuring lives of debtors.)		
IC 27-8-5-19(c)(14)	PHYSICAL EXAMINATION AND AUTOPSY: Insurer has the right to examine the person during the pendency of a claim or to conduct an autopsy in case of death, unless prohibited by law.		
IC 27-8-5-19(c)(15)	LEGAL ACTIONS: No lawsuit may be filed to recover under the policy before 60 days after proof of loss is filed, and not later than 3 years after proof of loss is required to be filed.		
IC 27-8-5-19(c)(16)	DEBTOR'S CERTIFICATE: If policy insures debtors, the Insurer will furnish to policyholder a certificate of insurance for each debtor insured, describing the coverage and benefits payable first to reduce or extinguish indebtedness.		
IC 27-8-5-19(c)(17)	PROTECTION FOR DISABLED DEPENDENT: If policy provides hospital or medical expense coverage of a dependent child and contains an attainment age provision, coverage cannot be terminated while the child is: a) incapable of self-sustaining employment because of mental retardation or mental or physical disability; and b) chiefly dependent on the member for support and maintenance. Proof must be provided within 120 days of limiting age, not more than once a year for next 2 years.		
IC 27-8-28 IC 27-8-29	GRIEVANCE AND APPEALS PROCEDURES: Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals, and (3) external appeals, and the related time frames for each tier.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 128	NOTICE: Notice to policyholders regarding filing complaints with the Department of Insurance		
C. Optional Provisions			
760 IAC 1-38.1	Coordination of Benefits – Required language if included		
D. Group A&H Policies must provide			
IC 27-8-5-15.6	MENTAL HEALTH PARITY; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136		
IC 27-8-5-21	ADOPTED CHILDREN		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-26	BREAST RECONSTRUCTION & PROSTHESIS following mastectomy—regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727		
IC 27-8-5-27	DENTAL ANESTHESIA/ HOSPITALIZATION		
IC 27-8-5-28 Bulletin 189	DEPENDENTS TO AGE 26: A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.		
IC 27-8-5.6-2(b)	NEWBORNS		
IC 27-8-14-6	MAMMOGRAPHY (Baseline, then 1 per year after 40 unless high risk)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 136 Bulletin 179	AUTISM SPECTRUM DISORDER (PREVIOUSLY PDD): As Per Bulletins 136 and 179, "Coverage for services will be provided as prescribed by the insured's treating physician in accordance with a treatment plan." Autism Spectrum Disorders include Asperger's Syndrome and Autism.		
IC 27-8-14.5	DIABETES TREATMENT , supplies, equipment & education		
IC 27-8-14.7	PROSTATE CANCER SCREENING (1 per year after 50 unless high risk) Due to EHB benchmark requirements, prostate cancer screening <u>must</u> be covered		
IC 27-8-14.8	COLORECTAL CANCER SCREENING Due to the EHB Benchmark requirements, colorectal cancer screening <u>must</u> be covered		
IC 27-8-24-4	MINIMUM POSTPARTUM STAY AND INFANT SCREENING TESTS required by IC 16-41		
IC 27-8-24.1-5	INHERITED METABOLIC DISEASE		
IC 27-8-24.2-5	ORTHOTIC AND PROSTHETIC DEVICES		
IC 27-8-24.3	VICTIMS OF ABUSE without regard to the abuse		
IC 27-8-26	Individuals without regard to GENETIC TESTING		
IC 27-8-20	OFF-LABEL USE OF CERTAIN DRUGS		
Bulletin 172	CHEMOTHERAPY PARITY		
760 IAC 1-39-7	AIDS, HIV and related conditions		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
E. Group A&H Policies <i>must</i> offer			
IC 27-8-14.1	MORBID OBESITY: Coverage for the surgical treatment of morbid obesity. For groups that choose to offer this benefit on the exchange, any premium related to this benefit would not be eligible for premium tax credit.		
F. General Regulatory Issues	Under the authority provided by IC 27-4-1-4, 27-8-5-1 and 27-8-5-1.5, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will also be reviewed.		
IC 27-8-5-1.5(l)(2)	APPLICATION QUESTIONS: 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.		
IC 27-8-5-1.5(l)(2)	ARBITRATION: Mandatory and/or binding arbitration provisions are prohibited.		
IC 27-8-5-1.5(l)(2)	LARGE ENDORSEMENTS: The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be re-filed to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.		
IC 27-8-5-1.5(l)(2)	OPEN ENDORSEMENTS: Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.		
IC 27-8-5-1.5(l)(2)	PROHIBITED PROVISIONS: The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1.5(l)(2)	PRIVACY OF HEALTH INFORMATION: Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have regarding an individual's health condition.		
IC 27-8-5-1.5(l)(2)	VARIOUS FEES: Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.		
IC 27-8-5-2.5 IC 27-8-5-19(c)(6) IC 27-8-15-27	FIRST MANIFEST LANGUAGE: Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.		
Bulletin 103	FULL AND FINAL DISCRETION: No full and final discretion clauses except where policy is governed by ERISA.		
Bulletin 106	FOREIGN LANGUAGE FORMS: Foreign language forms must comply with Bulletin 106.		
G. ACA Must Provide	All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – AMBULATORY PATIENT SERVICES ACA §1302		
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – EMERGENCY SERVICES ACA §1302		
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – HOSPITALIZATION ACA §1302		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – MATERNITY AND NEWBORN CARE Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302		
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT ACA §1302		
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – PRESCRIPTION DRUGS ACA §1302		
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302		
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – LABORATORY SERVICES ACA §1302		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130		
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE Insurer must indicate if Pediatric dental services are being included and excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302		
IC 27-8-5-1(c)	LIMITATIONS ON ESSENTIAL HEALTH BENEFITS: The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS <i>Please acknowledge</i> PHSA §2711 75 Fed Reg 37188 45 CFR §147.126		
IC 27-8-5-1(c)	MATERIAL MODIFICATIONS Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits <i>Please acknowledge</i> PHSA §2715 75 Fed Reg 41760		
IC 27-8-5-1(c)	COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW") Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections <i>Please acknowledge</i> PHSA §2728 45 CFR §147.145		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). <i>Please acknowledge</i> 45 CFR §156.122(a)		
IC 27-8-5-1(c)	SUMMARY OF BENEFITS COVERAGE: The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. <i>Please acknowledge</i> PHSA §2715		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	NO PRE-EXISTING CONDITION EXCLUSIONS: A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage. <i>Please acknowledge</i> PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108		
IC 27-8-5-1(c)	MARKETING: Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(e)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	PROHIBITION ON DISCRIMINATION: The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125		
IC 27-8-5-1(c)	GUARANTEED AVAILABILITY OF COVERAGE: Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	OPEN ENROLLMENT: Insurer must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. Insurer may limit the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules defined in the Affordable Care Act and pursuant to applicable state law. If the plan is offered in SHOP, coverage must be effective consistent with the dates mandated by the SHOP Exchange even if plan is off Exchange. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(b)		
IC 27-8-5-1(c)	SPECIAL ENROLLMENT: Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 30 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(b) 45 CFR §155.410		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	SPECIAL RULES FOR NETWORK PLANS: (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.104(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	APPLICATION OF FINANCIAL CAPACITY LIMITS: Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.104(d)		
IC 27-8-5-1(c)	GUARANTEED RENEWABILITY OF COVERAGE: Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.106(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS: Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)		
IC 27-8-5-1(c)	DISCONTINUING PRODUCTS: Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.106(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	DISCONTINUING ALL COVERAGE: Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. <i>Please acknowledge</i> 45 CFR §147.106(d)		
IC 27-8-5-1(c)	UNIFORM MODIFICATION OF COVERAGE: Insurer may only modify coverage at the time of coverage renewal. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(e)		
IC 27-8-5-1(c)	COVERAGE THROUGH ASSOCIATIONS: Any reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)		
IC 27-8-5-1(c)	CLINICALLY APPROPRIATE DRUGS: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	EMERGENCY DEPARTMENT SERVICES: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	CATASTROPHIC PLANS: If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
H. Specific Requirements for Qualified Health Plans in SHOP	Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated. All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)		
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)		
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)		
	PARTICIPATION RULES: Insurers offering a QHP through the SHOP may impose group participation rules for the offering of health insurance coverage in connection with a QHP 45 CFR §156.285 (e)		
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)		
	WAITING PERIODS: Group health plans may not impose waiting periods in excess of 90 days from the date on which an employee would be otherwise eligible for participation in the group health plan. Any special enrollment for newly eligible employees would occur at the expiration of any waiting period. PHSA §2708		
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify policy holder to contact the FFM for any changes to their eligibility determination. <i>Please acknowledge</i> 45 CFR §155.330		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
I. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated. All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, <u>either on or off the Exchange</u>. This type of plan has an effective date on or after January 1, 2014.		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.		

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature: _____

Printed Name: _____

Title: _____

Company: _____

Date: _____

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Anthem Insurance Companies, Inc.
State:	Indiana
HIOS Issuer ID:	17575
NAIC Company Code:	28207
Market:	Small Group
Effective Date:	January 1, 2015

- Company Contact Information

Primary Contact Name:	Aaron Smith
Primary Contact Telephone Number:	(317) 287-6452
Primary Contact Email Address:	Aaron.Smith@wellpoint.com

2. Scope and Purpose of the Filing

To the best of Anthem's knowledge and current understanding, this filing complies with the most recent regulations and related guidance. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required.

The purpose of this rate filing is to establish rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). The rates will be in-force for effective dates on or after January 1, 2015. Subsequent rate changes will be implemented quarterly as discussed in more detail in Section 16: Index Rate. These rates will apply to plans offered both On-Exchange and Off-Exchange. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):

ABCBS-SG HMO ON/OFF EXCH-v02
ABCBS-SG POS ON/OFF EXCH-v02
ABCBS-SG PPO OFF EXCH-v02

3. Introduction

This filing includes an average rate increase of 3.5%, with range by plan between -1.8% and 16.8%. More details are provided below in Section 5: Proposed Rate Increase, and in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

- Changes from 2014 Filings

Tobacco rating factors have been set to 1.0 – see Exhibit J: Age and Tobacco Factors.

Area factors have been adjusted to reflect most current experience. Refer to Exhibit K: Area Factors.

This filing includes new exhibits showing the Market Adjusted Index Rate, Plan Adjusted Index Rate, and Consumer Adjusted Premium Rates, as defined in the new memo instructions for 2015 filings. See Exhibit O: Quarterly Index, Base, and Market Adjusted Index Rate Development and Exhibit P: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

4. Description of How the Base Rate Is Determined

The development of the Base Rate is detailed in Exhibit A: Base Rate Development. Further details on how the base rate is developed can be found in Section 9: Credibility Manual Rate Development, Section 12: Risk Adjustment and Reinsurance, Section 13: Non-Benefit Expenses, Profit and Risk, and Section 19: Calibration. A description of the methodology used to determine the base rate is as follows:

- Small Group manual rates are developed based on historical experience of Grandfathered and Non-Grandfathered business.
- The experience data is normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period based on expected distribution of membership.
- The projected claims cost is calculated by adjusting the normalized claims for the impact of benefit changes, population morbidity, trend factors, other cost of care impacts and other claim adjustments.
- The projection period is February 1, 2015 - January 31, 2016. Small Group Business renews on a quarterly basis; therefore the middle month of the first quarter is February 2015 .
- Adjustments for risk adjustment and reinsurance are applied to the projected claims cost.
- Non-benefit expenses, profit, and risk are applied to the projected claims cost to determine the required projection period premium.
- The projection period premium is adjusted by the average rating factors in the projection period to determine the base rate.
- The base rate represents an average benefit plan and area for an age 21 non-tobacco user in Indiana.

Premiums at the member level are determined by multiplying the base rate by the applicable factor for each of the allowable rating criteria: age, tobacco, area and benefit plan. An example of this calculation is shown in Exhibit L: Sample Rate Calculation.

5. Proposed Rate Increase

The average proposed rate increase is 3.5%. Factors that affect the proposed rate increase for all plans include:

- Changes in benefit design
- Anticipated changes in the market-wide morbidity of the covered population in the projection period
- Changing trends in medical costs and utilization and other cost of care impacts
- Anticipated changes in payments to the Federal Transitional Reinsurance Program
- Changes in taxes, fees, and other non-benefit expenses

The rate increase is shown in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

Although rates are based on the same single risk pool of experience, proposed rate increases vary by plan from -1.8% to 16.8%. Factors that affect the variation in the proposed rate increase by plan include:

- Changes in benefit design that vary by plan
- Changes in the adjustment factor for Catastrophic eligibility
- Changes in Non-Benefit Expenses that are applied on a PMPM basis
- Changes in the underlying area rating factors

These rate increases by plan are shown in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

6. Experience Period Premium and Claims

Experience shown in Worksheet 1, Section I of the Unified Rate Review Template is for the Indiana Small Group Single Risk Pool Non-Grandfathered Business. This experience is given 0% credibility in the development of manual rates. This is not due to the amount of experience in Worksheet 1, Section I of the Unified Rate Review Template, but rather 0% credibility is applied to this experience because we have instead used combined Grandfathered and Non-Grandfathered Small Group experience in the development of manual rates, as described in Section 10: Credibility of Experience. The manual rates are fully detailed in Section 9: Credibility Manual Rate Development.

Claims experience in Worksheet 1, Section I of the Unified Rate Review Template reflects dates of service from January 1, 2013 through December 31, 2013.

- Paid Through Date

Claims shown in Worksheet 1, Section I of the Unified Rate Review Template are paid through March 31, 2014.

- **Allowed and Incurred Claims Incurred During the Experience Period**

The allowed claims are determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

Allowed and incurred claims are completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of claims paid for a particular month after one month of run out, two months, etc., for a forty-eight month view of history. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

- **Premiums (net of MLR Rebate) in Experience Period**

The estimated Non-Grandfathered gross earned premium for Indiana Small Group is \$612,662,491, where earned premium is the pro-rata share of premium owed to Anthem due to subscribers actively purchasing insurance coverage during the experience period.

The preliminary MLR Rebate estimate is -\$8,548,684, (approximately 75% of which is attributable to the 2-50 group size market), which is consistent with the December 31, 2013 Anthem general ledger estimate allocated to the Non-Grandfathered portion of Small Group. Note that this is an estimate and will not be final until June 1, 2014.

7. Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

- **Inpatient Hospital:** Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- **Outpatient Hospital:** Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- **Professional:** Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- **Other Medical:** Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- **Capitation:** Includes all services provided under one or more capitated arrangements.

- Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

8. Projection Factors

As previously indicated, the credibility level assigned to the experience in Worksheet 1, Section III of the Unified Rate Review Template is 0%. Consequently, factors to project experience claims are not provided as they are not applicable. However, the factors used to develop the manual rates are fully detailed in Section 9: Credibility Manual Rate Development.

- Changes in the Morbidity of the Population Insured

n/a - see Credibility Manual Rate Development

- Changes in Benefits

n/a - see Credibility Manual Rate Development

- Changes in Demographics

n/a - see Credibility Manual Rate Development

- Other Adjustments

n/a - see Credibility Manual Rate Development

- Trend Factors (cost/utilization)

n/a - see Credibility Manual Rate Development

9. Credibility Manual Rate Development

Experience developed and projected herein is Anthem's Small Group Business based on plan liability amounts. The rate development is shown in Exhibit A: Base Rate Development.

- Source and Appropriateness of Experience Data Used

The source data underlying the development of the manual rate consists of claims for all Grandfathered and Non-Grandfathered Small Group business, incurred during the period January 1, 2013 – December 31, 2013 and paid through March 31, 2014. Completion factors are then calculated to reflect additional months of runout after March 31, 2014. Anthem expects a portion of the Grandfathered policyholders to migrate to ACA-compliant policies prior to and during the projection period.

In developing rates effective January 1, 2015, only limited 2014 experience is available. This experience is not deemed credible for purposes of rate development.

Other than completing the incurred claims, no further explicit adjustments are made to the experience data.

For more detail, see Exhibit B: Claims Experience for Manual Rate Development.

- **Adjustments Made to the Data**

The development of the projected claims is summarized in Exhibit A: Base Rate Development, items (1) - (10), and described in detail below.

The projected claims cost is calculated by multiplying the normalized claims cost by the impact of benefit changes, anticipated changes in population morbidity, and cost of care impacts. The adjustments are described below, and the factors are presented in Exhibit D: Projection Period Adjustments. In addition, the source data is normalized for seasonality and changes in the provider contracts.

Changes in Demographics (Normalization)

The source data was normalized to reflect anticipated changes in age/gender, area, network, and benefit plan from the experience period to the projection period. The purpose of these factors is to adjust current experience to be reflective of expected claim experience in the projection period. See Section 23: Membership Projections for additional information on membership movement. The normalization factors and their aggregate impact on the underlying experience data are detailed in Exhibit C: Normalization Factors.

- **Age/Gender:** The assumed claims cost is applied by age and gender to the experience period distribution and the projection period distribution.
- **Area/Network:** The area claims factors are developed based on an analysis of Small Group and Individual allowed claims by network, mapped to the prescribed 2015 rating areas using 5-digit zip code.
- **Benefit Plan:** The experience period claims are normalized to an average 2015 plan using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

Changes in Benefits

Benefit changes include the following:

- **Preventive Rx (over the counter):** The claims are adjusted for 100% coverage of benefits for specific over the counter drugs obtained with a prescription from a physician.
- **Rx Adjustments:** The claims are adjusted for differences in the Rx formulary and the impact of moving drugs into different tiers in the projection period relative to what is reflected in the base experience data.

Changes in the Morbidity of the Population Insured

The claims are adjusted to reflect shifts in health insurance coverage as a result of the provisions of the ACA. The market shifts, or population movements, affecting the morbidity of the Small Group market in the projection period include:

- Small Groups electing to drop coverage
- Small Group members electing to be uninsured
- Small Groups moving to self-funded coverage
- Small Group members moving to Medicaid
- Small Group members electing to forego COBRA coverage upon termination
- Small Groups electing to remain on their current (non-ACA) products in 2015

The movement assumptions above are based on market research and assumptions on the employer opt-out and consumer uptake rates. The morbidity impacts of population movement are based on health status determined from internal risk score data.

Our goal is to price to the average risk of the 2015 ACA market. Since Anthem-specific 2013 experience was used as a starting point, we adjusted this experience to be more consistent with the overall 2013 market in Indiana. Wakely Consulting collected demographic and risk information from carriers, and calculated Anthem's relative risk to the market for 2013. We have adjusted our starting experience using the results of that survey.

Trend Factors

- The annual pricing trend used in the development of the rates is 11.2%. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, and the result is projected forward. The trend includes a volatility provision in accordance with Actuarial Standards of Practice. The claims are trended 25 months from the midpoint of the experience period, which is July 1, 2013, to the midpoint of the projection period, which is August 1, 2015.
- Projected trends include the estimated cost during 2014 and 2015 of the pharmaceutical Sovaldi and other high-cost drugs for treating Hepatitis C. These cost estimates were based on claims experience for Indiana Small Group business, together with CDC recommendations and Industry and Enterprise data.

Other Cost of Care Impacts

- Composite rating : As per the Notice of 2015 Benefit and Payment Parameters, composite rating will be available to all group sizes. Prior to 2014, composite rating has been offered to group sizes 10 and above. An adjustment is being made to the rates to reflect the anti-selective impact of composite rating smaller group sizes.
- Utilization or cost-per-service change: anticipated changes are reflected in the morbidity changes and trend.
- Change in Medical Management: medical management savings not already included in the claims experience and trend.
- Change in Provider Contracts: anticipated changes in provider contracts are reflected in the benefit plan factors and the region rating factors.

Other Claim Adjustments

The adjustments described below are presented in Exhibit E: Other Claim Adjustments.

- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.
- The cost of adding benefits for pediatric dental and vision are included.
- The cost of adding benefits for Clinical Care Packages is included.

• Capitation Payments

The underlying data includes capitation payments, which are combined with the base medical and pharmacy claims and projected at the same rate. No further adjustment is made to the capitation.

10. Credibility of Experience

The combination of both Grandfathered and Non-Grandfathered experience data most reasonably reflects Small Group claims experience under the future projection period. Actuarial judgment has been exercised to determine that rates will be developed giving full credibility to the data underlying the manual rate in Section 9: Credibility Manual Rate Development.

• Resulting Credibility Level Assigned to Base Period Experience

The credibility level assigned to the experience in Worksheet 1, Section III of the Unified Rate Review Template is 0%.

11. Paid to Allowed Ratio

The 'Paid to Allowed Average Factor in Projection Period' shown in Worksheet 1, Section III of the Unified Rate Review Template is developed by membership-weighted essential health benefit paid claims divided by membership-weighted essential health benefit allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

12. Risk Adjustment and Reinsurance

- **Projected Risk Adjustment**

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. The HHS operated Risk Adjustment program is supported by a user fee, as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

Anthem is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

- **Projected ACA Reinsurance Recoveries Net of Reinsurance Premium**

The transitional reinsurance risk mitigation program collects funds from all insurance issuers and TPAs and redistributes them to high cost claimants in the Non-Grandfathered Individual market. The reinsurance contribution is equal to the national per capita reinsurance contribution rate as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

13. Non-Benefit Expenses, Profit and Risk

Non-Benefit expenses are detailed in Exhibit G: Non-Benefit Expenses and Profit & Risk.

- **Administrative Expense**

Administrative Expenses are expected to be consistent with historical levels and are developed utilizing the same methodology as previous filings, they are not varied by product or plan. Maintenance costs are assumed to be flat on a per member basis with savings from administrative efficiencies and the elimination of underwriting offset by new expenses for risk management and regulatory compliance.

- **Quality Improvement Expense**

The quality improvement expense represents Anthem's dedication to providing the highest standard of customer care and consistently seeking to improve health care quality, outcomes and value in a cost efficient manner.

The QI Expense assumptions are based on historical amounts related to the following initiatives: Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, HIT Expenses for Health Care Quality Improvements, Other Cost Containment and ICD-10.

- **Selling Expense**

Selling Expense represents broker commissions and bonuses associated with the broker distribution channel using historical and projected commission levels. Commissions will be paid both On-Exchange and Off-Exchange.

- **Taxes and Fees**

- **Patient-Centered Outcomes Research Institute (PCORI) Fee:** The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund. For plan years ending before October 1, 2014, the fee is \$2 per member per year. Thereafter, for every plan year ending before October 1, 2019, the fee will increase by the percentage increase in National Healthcare Expenditures.
- **ACA Insurer Fee:** The health insurance industry will be assessed a permanent fee, based on market share of net premium, which is not tax deductible. The tax impact of non-deductibility is captured in this fee.
- **Exchange Fee:** The Exchange User Fee applies to Exchange business only, but the cost is spread across all Small Group plans. A blended fee/percentage is determined based on an assumed 10% of members that will purchase products On-Exchange. The resulting fee/percentage is applied evenly to all plans in the risk pool, both On and Off Exchange.
- **Premium taxes, federal income taxes and state income taxes** are also included in the retention items.

- **Profit**

Profit is reflected on a post-tax basis as a percent that does not vary by product or plan. The profit percentage does not include any assumed risk corridor payments or receipts.

14. Projected Loss Ratio

- **Projected Federal MLR**

The projected Federal MLR for the products in this filing is estimated in Exhibit M: Federal MLR Estimated Calculation. Please note that this calculation is purely an estimate and not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only a subset of Anthem's Small Group business. The MLR for Anthem's entire book of Small Group business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

15. Single Risk Pool

As described above in Section 4: Description of How the Base Rate Is Determined, the Anthem Index Rate for Small Group business in Indiana is based on total combined claims costs for providing essential health benefits within the single risk pool of non-grandfathered Small Group plans in Indiana. The Index Rate is adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and Exchange user fees. The premium rates for all Anthem non-grandfathered plans in the Small Group market use the applicable market-wide adjusted index rate, subject only to the permitted plan-level adjustments. This demonstrates that the Single Risk Pool for Anthem Small Group business is established according to the requirements in 45 CFR part 156, §156.80(d).

16. Index Rate

- **Experience Period Index Rate**

The index rate represents the average allowed claims PMPM of essential health benefits for Anthem's Small Group Non-Grandfathered Business. The experience period index rate shown in Worksheet 1, Section I (cell G17) of the Unified Rate Review Template is \$363.00 and is the same as the experience period allowed claims (cell G16 in the same location). A comparison to the benchmark was performed, and only essential health benefits were covered during the experience period.

- **Projection Period Index Rate**

The index rate represents the average allowed claims PMPM of essential health benefits for Anthem's Small Group Non-Grandfathered Business. The projection period index rate was developed as shown in Exhibit N: Index Rate Development by adjusting the projected incurred claims PMPM described in Section 9: Credibility Manual Rate Development of this memorandum. No benefits in excess of the essential health benefits are included in the projection period allowed claims (cell T30 of Worksheet 1, Section II of the Unified Rate Review Template) or Exhibit N: Index Rate Development's projection period index rate (also shown in cell V44 of Worksheet 1, Section III of the Unified Rate Review Template).

- Quarterly Index and Base Rate

Quarterly index and base rate changes will be implemented On-Exchange and Off-Exchange. See Exhibit O: Quarterly Index, Base, and Market Adjusted Index Rate Development.

17. Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market wide modifiers defined in the market rating rules. This development is presented in Exhibit N: Index Rate Development and Exhibit O: Quarterly Index, Base, and Market Adjusted Index Rate Development.

18. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. This development is presented in Exhibit P: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

- Plan Level Modifiers
 - Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan, based on the AV metal value with an adjustment for utilization differences due to differences in cost sharing. See Exhibit H: Calibration.
 - Provider Network Adjustments: This is a multiplicative factor that adjusts for differences in projected claims cost due to different network discounts.
 - Adjustments for Benefits in Addition to EHBs: This multiplicative factor adjusts for additional benefits that are not EHBs.
 - Adjustments for administrative cost: This is an additive adjustment that includes all the Selling Expense, Administration and Other Retention Items shown in Exhibit G: Non-Benefit Expenses and Profit & Risk, with the exception of the Exchange User Fee.

19. Calibration

The required premium in the projection period is calibrated by the average rating calibration factors (Age, Area, and Plan Factor), which are used to develop the Consumer Adjusted Premium Rates. The average rating factors are shown in Exhibit H: Calibration, Exhibit P: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates, and applied in line item 14 of Exhibit A: Base Rate Development.

- **Benefit Plan Factors**

The benefit plan rating factors are applied to the projection period distribution.

Benefit plan factors also consider the following adjustments, as applicable.

- Induced Utilization Adjustment: The induced utilization adjustment accounts for member behavior variations depending on the richness of the benefit design.
- Pediatric Dental and Vision Benefits: For plans excluding the pediatric dental benefit and pediatric vision benefit, the benefit plan factor reflects reduced benefits.
- Non-EHBs: For plans including benefits in addition to EHBs, the benefit plan factor reflects enhanced benefits.
- Provider Network: This factor accounts for differences in contracted rates and network structure.

Refer to Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

- **Age Factors**

- Refer to Exhibit J: Age and Tobacco Factors.

- **Area Factors**

Area factors have been adjusted to reflect the most current experience. Refer to Exhibit K: Area Factors.

20. Consumer Adjusted Premium Rate

The Consumer Adjusted Premium Rate is calculated as the Plan Adjusted Index Rate calibrated as described in the previous section. This development is presented in Exhibit P: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates. The calibration is shown in Exhibit H: Calibration.

21. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values included in Worksheet 2 of the Unified Rate Review Template are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. Benefits for Plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

22. Actuarial Value Pricing Values

The AV Pricing Values for each Product ID are in Worksheet 2, Section I of the Unified Rate Review Template. The fixed reference plan selected as the basis for the AV Pricing Value calculations is '17575IN0740009'. Consistent with final Market rules, utilization adjustments are made to account for member behavior variations based upon cost-share variations of the benefit design and not the health status of the member. The average allowable modifiers to the Index Rate can be found in Exhibit P: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

23. Membership Projections

Membership projections in Worksheet 2 of the Unified Rate Review Template are developed using a population movement model plus adjustments for sales expectations. This model projects the membership in the projection period by taking into account:

- Small Groups dropping coverage
- Small Group members opting out of coverage
- Small Group members moving to Medicaid
- Small Group members electing to forego COBRA coverage upon termination

The plan distribution is based on assumed metal tier and network distributions. Some 2014 preliminary enrollment information has been considered in projecting membership distributions.

The projected morbidity changes shown in Exhibit D: Projection Period Adjustments include expected morbidity changes due to population movement.

24. Warning Alerts

There are warning alerts in cells A80 and A82 on Worksheet 2, Section IV of the Unified Rate Review Template. This is because the Small Group Plan Adjusted Index Rates reflect the member weighted average of the rates for all effective dates in the filing, whereas the Worksheet 1 Single Risk Pool Gross Premium Avg. Rate reflects the effective date of the change in the Index Rate.

25. Plan Type

Plan types in Worksheet 2, Section I of the URRT adequately describe Anthem's plans.

26. Reliance

In support of this rate development, various data and analyses were provided by other members of Anthem's internal actuarial staff, including data and analysis related to cost of care, valuation, and pricing. I have reviewed these data and analyses for reasonableness and consistency. I have also relied on Brian Renshaw, FSA, MAAA to provide the actuarial certification for the Unique Plan Design Supporting Documentation and Justification for plans included in this filing.

27. Actuarial Certification

I, Nicole Styka, FSA, MAAA, am an actuary for Anthem. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The projected Index Rate is:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient.

(2) The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

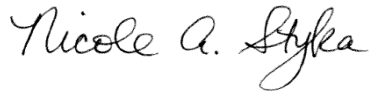
(3) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

(4) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

(5) On/Off Exchange Attestation: A single base premium rate has been developed for both on and off exchange plans using the same underlying experience data. The premium rates for on and off exchange plans vary only due to differences in the provider network and benefit design.

(6) QHP Off Exchange Premium Tax Credit (PTC) Attestation: Consumers applying for plans off exchange have been notified that the plan is not eligible for a Premium Tax Credit.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-Facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, used consistently, and only adjusted by the allowable modifiers. However, this Actuarial Memo does accurately describe the process used by the issuer to develop the rates.



Nicole Styka, FSA, MAAA
Regional Vice President and Actuary III

May 9, 2014

Date

Exhibit A - Base Rate Development

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

	<u>Paid Claims</u>	
1) Experience Period Cost PMPM	\$ 274.62	Exhibit B
2) x Normalization Factor	1.0053	Exhibit C
3) = Normalized Claims	\$ 276.07	= (1) x (2)
4) x Benefit Changes	0.9870	Exhibit D
5) x Morbidity Changes	1.0643	Exhibit D
6) x Trend Factor	1.2475	Exhibit D
7) x Other Cost of Care Impacts	1.0300	Exhibit D
8) = Projected Claim Cost	\$ 372.63	= (3) x (4) x (5) x (6) x (7)
9) + Other Claim Adjustments	\$ (3.90)	Exhibit E
10) = Claims Projected to Projection Period	\$ 368.73	= (8) + (9)
11) + Risk Adjustment and Reinsurance - Contributions and Payments	\$ 3.63	Exhibit F
12) + Non-Benefit Expenses and Profit & Risk {1}	\$ 125.51	Exhibit G
13) = Required Premium in Projection Period	\$ 497.87	= (10) + (11) + (12)
14) ÷ Calibration Factor	1.4228	Exhibit H
15) = Required Base Rate (Average Plan Level - Age 21 - Non-Tobacco)	\$ 349.92	= (13) ÷ (14)
16) Projected Loss Ratio (Conventional Basis)	74.8%	= [(10) + (11)] ÷ (13)

NOTES:

{1} Equivalent to PMPM expenses on Exhibit G + % of premium expenses on Exhibit G applied to Required Premium (Row 13 above).

Exhibit B - Claims Experience for Manual Rate Development

Anthem Insurance Companies, Inc.
Small Group

Incurred January 1, 2013 through December 31, 2013
Paid through March 31, 2014

PAID CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
\$ 322,870,206	\$ 74,804,006	\$ 35,929,651	\$ 3,193,454	\$ 358,799,857	\$ 77,997,460	\$ -	\$ 436,797,317	1,590,565	\$	274.62

ALLOWED CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
\$ 436,864,298	\$ 104,955,107	\$ 46,669,888	\$ 4,232,648	\$ 483,534,186	\$ 109,187,755	\$ -	\$ 592,721,941	1,590,565	\$	372.65

Exhibit C - Normalization Factors

Anthem Insurance Companies, Inc.
Small Group

Rates Effective January 1, 2015

	Average Claim Factors		Normalization Factor
	Experience Period Population	Future Population	
Age/Gender	0.9655	1.0384	1.0755
Area/Network	1.0005	0.9967	0.9962
Benefit Plan	0.7508	0.7045	0.9383
Total			1.0053

Exhibit D - Projection Period Adjustments

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

<i>Impact of Changes Between Experience Period and Projection Period:</i>	
	<u>Adjustment Factor</u>
<u>Benefit changes</u>	
Preventive Rx (over the counter)	1.0001
Rx Adjustments {1}	0.9869
Total Benefit Changes	0.9870
<u>Morbidity changes</u>	
Total Morbidity Changes	1.0643
<u>Cost of care impacts</u>	
Annual Medical/Rx Trend Rate	11.20%
# Months of Projection	25
Trend Factor	1.2475
Composite Rating	1.0300
Total other Impacts	1.0300

NOTES:

{1} Includes Rx formulary and impacts for moving drugs into different tiers

Exhibit E - Other Claim Adjustments

Anthem Insurance Companies, Inc.
Small Group

Rates Effective January 1, 2015

<i>Adjustments to projection period claims to reflect covered benefits not included in experience period data:</i>	
	<u>PMPM</u>
Rx Rebates	(\$6.76)
Pediatric Dental	\$0.93
Pediatric Vision	\$1.13
CCP Packages	\$0.80
Total	(\$3.90)

NOTES:

Adjustments above reflect ONLY additional costs beyond those already captured in line Item 8 of Exhibit A.

Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

<u>Risk Adjustment:</u>			
PMPM	User Fee	Net Transfer	
Federal Program	\$0.08	\$0.00	
<u>Note:</u>			
It is assumed the risk for the plans included in this rate filing is no better/worse than any other plans within this market.			
<u>Reinsurance:</u>			
PMPM	Contributions Made	Expected Receipts	
Federal Program	\$3.55	\$0.00	<i>Small Group Plans contribute funds but only Individual Plans are eligible to receive payments</i>
<u>Source:</u>			
HHS estimates a national per capita contribution rate of \$3.67 per month (\$44 per year) in benefit year 2015 (per Payment Parameter Rule).			
Grand Total of All Risk Mitigation Programs			\$3.63

NOTES:

\$3.55 = \$3.67*(11 months/12 months)+\$2.30*(1 month/ 12 months)

\$3.67 = 2015 contribution

\$2.30 = 2016 contribution

Exhibit G - Non-Benefit Expenses and Profit & Risk

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

	Expenses Applied As a PMPM Cost	Expenses Applied as a % of Premium	Expressed as a PMPM {1}
Administrative Expenses			
Administrative Costs	\$16.24		
Quality Improvement Expense	\$3.34		
Selling Expense	\$15.85		
Selling Expense		0.00%	
Specialty Expenses	\$0.33		
Total Administrative Expenses	\$35.76	0.00%	\$35.76
Taxes and Fees			
PCORI Fee	\$0.18		
ACA Insurer Fee		3.79%	
Exchange Fee		0.35%	
Premium Tax		0.00%	
MLR-Deductible Federal/State Income Taxes {2}		5.24%	
Total Taxes and Fees	\$0.18	9.38%	\$46.88
Profit and Risk {3}		8.61%	\$42.87
Total Non-Benefit Expenses, Profit, and Risk	\$35.94	17.99%	\$125.51

NOTES:

{1} The sum of the rounded percentages shown may not equal the total at the bottom of the table due to rounding.

{2} Includes only those income taxes which are deductible from the MLR denominator; in particular, Federal income taxes on investment income are excluded.

{3} Profit shown here is post-tax profit, net of those federal and state income taxes which are deductible from the MLR denominator.

Exhibit H - Calibration

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

<i>Average 2015 rating factors for 2015 population:</i>	
	Calibration Factors
Age	1.4228
Area	1.0000
Benefit Plan	1.0000
Total Calibration Factor	1.4228

NOTES:

See Line Item 14 on Exhibit A.

The base rate is developed by dividing the required premium in the projection period by the total average rating factor shown above.

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off		Benefit Plan		Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
		Exchange	Metal Level	Factor	Network Name			
Anthem Bronze Blue Preferred X HMO 6000/30%/6600 Plus	17575IN0720010	On/Off	Bronze	0.8396	IN SG::Blue Preferred - HMO	01,02,03,04,05,06,07,08,09,10,11,12,13,14,15,16,17	17575IN0720001	7.60%
Anthem Silver Blue Preferred X HMO 3000/20%/4500 Plus	17575IN0720008	On/Off	Silver	0.9717	IN SG::Blue Preferred - HMO	01,02,03,04,05,06,07,08,09,10,11,12,13,14,15,16,17	17575IN0720002	12.34%
Anthem Silver Blue Preferred X HMO 2000/30%/5500 Plus	17575IN0720009	On/Off	Silver	0.9804	IN SG::Blue Preferred - HMO	01,02,03,04,05,06,07,08,09,10,11,12,13,14,15,16,17	17575IN0720007	9.38%
Anthem Gold Blue Preferred X HMO 1250/10%/6350 Plus w/HSA	17575IN0720011	On/Off	Gold	1.1036	IN SG::Blue Preferred - HMO	01,02,03,04,05,06,07,08,09,10,11,12,13,14,15,16,17	17575IN0720003	1.02%
Anthem Bronze Blue Preferred X POS 6000/30%/6600 Plus	17575IN0730003	On/Off	Bronze	0.8396	IN SG::Blue Preferred - POS	01,02,03,04,05,06,07,08,09,10,11,12,13,14,15,16,17	17575IN0730001	7.60%
Anthem Bronze Blue Access PPO 5900/0%/6600 Plus	17575IN0740007	Off	Bronze	0.8713	IN SG::Blue Access	All	17575IN0800003	16.80%
Anthem Bronze Blue Access PPO 5000/20%/6350 Plus w/HSA	17575IN0740010	Off	Bronze	0.7176	IN SG::Blue Access	All	17575IN0800108	-1.12%
Anthem Bronze Blue Access PPO 5000/50%/6350 Plus w/HSA	17575IN0740011	Off	Bronze	0.6979	IN SG::Blue Access	All	17575IN0800107	-1.10%
Anthem Bronze Blue Access PPO 4000E/20%/6350 w/HSA	17575IN0740025	Off	Bronze	0.8446	IN SG::Blue Access	All	None	n/a
Anthem Bronze Blue Access PPO 5500E/0%/5500 w/HSA	17575IN0740026	Off	Bronze	0.8608	IN SG::Blue Access	All	17575IN0800091	6.35%
Anthem Bronze Blue Access PPO 3000/50%/6350 w/HSA	17575IN0740027	Off	Bronze	0.7743	IN SG::Blue Access	All	None	n/a
Anthem Bronze Blue Access PPO 6300/0%/6300 w/HSA	17575IN0740028	Off	Bronze	0.7543	IN SG::Blue Access	All	17575IN0800088	-1.75%
Anthem Bronze Blue Access PPO 4500/20%/6350 w/HSA	17575IN0740029	Off	Bronze	0.7637	IN SG::Blue Access	All	None	n/a
Anthem Bronze Blue Access PPO 5000E/20%/6350 w/HSA	17575IN0740030	Off	Bronze	0.7941	IN SG::Blue Access	All	17575IN0800093	5.67%
Anthem Bronze Blue Access PPO 3500E/20%/6450 w/HSA	17575IN0740031	Off	Bronze	0.8644	IN SG::Blue Access	All	None	n/a
Anthem Bronze Blue Access PPO 4500E/0%/6350 w/HSA	17575IN0740032	Off	Bronze	0.8633	IN SG::Blue Access	All	17575IN0800092	6.98%
Anthem Bronze Blue Access PPO 4500/30%/6350 w/HSA	17575IN0740033	Off	Bronze	0.7460	IN SG::Blue Access	All	None	n/a
Anthem Silver Blue Access PPO 2500/20%/6350 Plus	17575IN0740009	Off	Silver	0.9691	IN SG::Blue Access	All	17575IN0800079	5.24%
Anthem Silver Blue Access PPO 2000/30%/4500 Plus w/HSA	17575IN0740012	Off	Silver	0.9288	IN SG::Blue Access	All	None	n/a
Anthem Silver Blue Access PPO 3000/0%/3000 Plus w/HSA	17575IN0740014	Off	Silver	0.9991	IN SG::Blue Access	All	None	n/a
Anthem Silver Blue Access PPO 4000/20%/6600	17575IN0740021	Off	Silver	0.9464	IN SG::Blue Access	All	17575IN0800064	4.06%
Anthem Silver Blue Access PPO 5000/20%/6350	17575IN0740022	Off	Silver	0.9135	IN SG::Blue Access	All	None	n/a
Anthem Silver Blue Access PPO 2000/50%/6350	17575IN0740023	Off	Silver	0.9645	IN SG::Blue Access	All	17575IN0800057	2.92%
Anthem Silver Blue Access PPO 5000/0%/6000	17575IN0740024	Off	Silver	0.9599	IN SG::Blue Access	All	None	n/a
Anthem Silver Blue Access PPO 4000E/0%/5000 w/HSA	17575IN0740035	Off	Silver	0.9245	IN SG::Blue Access	All	17575IN0800153	6.30%
Anthem Silver Blue Access PPO 1500/20%/5000 w/HSA	17575IN0740036	Off	Silver	1.0272	IN SG::Blue Access	All	17575IN0800155	1.52%
Anthem Silver Blue Access PPO 2500/20%/4500 w/HSA	17575IN0740038	Off	Silver	0.9408	IN SG::Blue Access	All	17575IN0800158	-0.27%
Anthem Silver Blue Access PPO 5500/0%/5500 w/HSA	17575IN0740039	Off	Silver	0.8114	IN SG::Blue Access	All	17575IN0800159	-1.07%
Anthem Silver Blue Access PPO 3000E/0%/3000 w/HSA	17575IN0740040	Off	Silver	1.0689	IN SG::Blue Access	All	17575IN0800164	5.07%
Anthem Gold Blue Access PPO 1000/20%/3000 Plus	17575IN0740008	Off	Gold	1.1601	IN SG::Blue Access	All	17575IN0800032	5.83%
Anthem Gold Blue Access PPO 2000/0%/2000 Plus w/HSA	17575IN0740013	Off	Gold	1.1330	IN SG::Blue Access	All	17575IN0800045	2.89%
Anthem Gold Blue Access PPO 1500/30%/5000	17575IN0740015	Off	Gold	1.1276	IN SG::Blue Access	All	None	n/a
Anthem Gold Blue Access PPO 3500/0%/4000	17575IN0740016	Off	Gold	1.1417	IN SG::Blue Access	All	17575IN0800013	0.69%
Anthem Gold Blue Access PPO 1500/30%/4000	17575IN0740017	Off	Gold	1.1603	IN SG::Blue Access	All	None	n/a
Anthem Gold Blue Access PPO 2500/20%/4500	17575IN0740018	Off	Gold	1.1104	IN SG::Blue Access	All	None	n/a
Anthem Gold Blue Access PPO 1000/20%/3500	17575IN0740019	Off	Gold	1.1616	IN SG::Blue Access	All	17575IN0800012	2.57%
Anthem Gold Blue Access PPO 1000/20%/5000	17575IN0740020	Off	Gold	1.1964	IN SG::Blue Access	All	17575IN0800011	2.07%
Anthem Gold Blue Access PPO 1250/10%/2250 w/HSA	17575IN0740034	Off	Gold	1.1632	IN SG::Blue Access	All	17575IN0800041	1.16%
Anthem Gold Blue Access PPO 2000/0%/2000 w/HSA	17575IN0740037	Off	Gold	1.1710	IN SG::Blue Access	All	None	n/a

NOTES:

Benefit Plan Factors above reflect plan by plan differences from the index rate for allowable adjustments as described in detail in the Market Reform and Payment Parameters Regulations and illustrated in Exhibit P. The weighted average of these adjustments for the entire risk pool included in this rate filing is detailed in Exhibit H.

Plan level increases in rates do not include demographic changes in the population.

Exhibit J - Age and Tobacco Factors

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

Age	Age Rating Factor	Tobacco Rating Factor
0-17	0.635	1.000
18	0.635	1.000
19	0.635	1.000
20	0.635	1.000
21	1.000	1.000
22	1.000	1.000
23	1.000	1.000
24	1.000	1.000
25	1.004	1.000
26	1.024	1.000
27	1.048	1.000
28	1.087	1.000
29	1.119	1.000
30	1.135	1.000
31	1.159	1.000
32	1.183	1.000
33	1.198	1.000
34	1.214	1.000
35	1.222	1.000
36	1.230	1.000
37	1.238	1.000
38	1.246	1.000
39	1.262	1.000
40	1.278	1.000
41	1.302	1.000
42	1.325	1.000
43	1.357	1.000
44	1.397	1.000
45	1.444	1.000
46	1.500	1.000
47	1.563	1.000
48	1.635	1.000
49	1.706	1.000
50	1.786	1.000
51	1.865	1.000
52	1.952	1.000
53	2.040	1.000
54	2.135	1.000
55	2.230	1.000
56	2.333	1.000
57	2.437	1.000
58	2.548	1.000
59	2.603	1.000
60	2.714	1.000
61	2.810	1.000
62	2.873	1.000
63	2.952	1.000
64+	3.000	1.000

NOTES:

{1} The weighted averages of these factors for the entire risk pool included in this rate filing is detailed in Exhibit H.

Exhibit K - Area Factors

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

Rating Area Description	Area Rating Factor
Region 1	0.9769
Region 2	1.0071
Region 3	0.9975
Region 4	1.0126
Region 5	0.9657
Region 6	0.9779
Region 7	0.9916
Region 8	0.9564
Region 9	0.9846
Region 10	1.0287
Region 11	1.0242
Region 12	0.9953
Region 13	1.0231
Region 14	0.9558
Region 15	1.0026
Region 16	0.7800
Region 17	0.9950
OOA	1.1650

NOTES:

{1} The weighted average of these factors for the entire risk pool included in this rate filing is detailed in Exhibit H.

{2} OOA = Out of Area

Exhibit L - Sample Rate Calculation

Anthem Insurance Companies, Inc.
Small Group

Rates Effective January 1, 2015

Group Name: Sample Group
Effective Date: 1/1/2015
On/Off Exchange: On
Metal Level: Bronze
Plan ID: 1757SIN0720010
Rating Area: Region 1

Group Census:

	Employee		Spouse		Child #1		Child #2		Child #3		Total Number of Children
	Age	Tobacco User	Age	Tobacco User	Age	Tobacco User	Age	Tobacco User	Age	Tobacco User	
Employee #1	24	Yes	23	No	0	No					1
Employee #2	26	No									
Employee #3	28	No									
Employee #4	32	Yes	33	No							
Employee #5	30	No			2	No	4	No			2
Employee #6	45	No	45	No	18	No	15	No	12	No	5
Employee #7	53	Yes	55	Yes							
Employee #8	41	No			16	No	13	No			2
Employee #9	56	No									
Employee #10	39	No			25	Yes					1
Employee #11	62	No									
Employee #12	64	No	64	No							

Calculation of Monthly Premium:

Base Rate =	\$	349.92	Exhibit A
x Benefit Plan Factor		0.8396	Exhibit I
<u>x Area Factor</u>		<u>0.9769</u>	Exhibit K
Base Rate Adjusted for Plan/Area =	\$	286.99	

Age/Tobacco Factors:

Exhibit J

	Employee		Spouse		Child #1		Child #2		Child #3		Number of Children Rated (1)
	Age Factor	Tobacco Factor	Age Factor	Tobacco Factor	Age Factor	Tobacco Factor	Age Factor	Tobacco Factor	Age Factor	Tobacco Factor	
Employee #1	1.000	1.0000	1.000	1.0000	0.635	1.0000					1
Employee #2	1.024	1.0000									
Employee #3	1.087	1.0000									
Employee #4	1.183	1.0000	1.198	1.0000							
Employee #5	1.135	1.0000			0.635	1.0000	0.635	1.0000			2
Employee #6	1.444	1.0000	1.444	1.0000	0.635	1.0000	0.635	1.0000	0.635	1.0000	3
Employee #7	2.040	1.0000	2.230	1.0000							
Employee #8	1.302	1.0000			0.635	1.0000	0.635	1.0000			2
Employee #9	2.333	1.0000									
Employee #10	1.262	1.0000			1.004	1.0000					1
Employee #11	2.873	1.0000									
Employee #12	3.000	1.0000	3.000	1.0000							

Final Monthly Premium PMPM:

	Employee	Spouse	Children	Total
Employee #1	\$ 286.99	\$ 286.99	\$ 182.24	\$ 756.22
Employee #2	\$ 293.88			\$ 293.88
Employee #3	\$ 311.96			\$ 311.96
Employee #4	\$ 339.51	\$ 343.81		\$ 683.32
Employee #5	\$ 325.73		\$ 364.48	\$ 690.21
Employee #6	\$ 414.41	\$ 414.41	\$ 546.72	\$ 1,375.54
Employee #7	\$ 585.46	\$ 639.99		\$ 1,225.45
Employee #8	\$ 373.66		\$ 364.48	\$ 738.14
Employee #9	\$ 669.55			\$ 669.55
Employee #10	\$ 362.18		\$ 288.14	\$ 650.32
Employee #11	\$ 824.52			\$ 824.52
Employee #12	\$ 860.97	\$ 860.97		\$ 1,721.94

NOTES:

- (1) As per the Market Reform Rule, when computing family premiums no more than the three oldest covered children under the age of 21 are taken into account whereas the premiums associated with each child age 21+ are included.
(2) This sample calculation ignores the tobacco offset under a Wellness Program as described in the Market Reform Rule.
(3) Minor rate variances may occur due to differences in rounding methodology.

Exhibit M - Federal MLR Estimated Calculation

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

Numerator:

Incurred Claims	\$	368.73	Exhibit A
+ Quality Improvement Expense	\$	3.34	Exhibit G
+ Risk Corridor Contributions	\$	-	
+ Risk Adjustment Net Transfer	\$	-	Exhibit F
+ Reinsurance Receipts	\$	-	Exhibit F
+ Risk Corridor Receipts	\$	-	
+ Reduction to Rx Incurred Claims (ACA MLR)	\$	(5.90)	
= <i>Estimated Federal MLR Numerator</i>	\$	366.17	

Denominator:

Premiums	\$	497.87	Exhibit A
- Federal and State Taxes	\$	26.09	Exhibit A (Line 13) x Exhibit G (Income Taxes)
- Premium Taxes	\$	-	Exhibit A (Line 13) x Exhibit G (Premium Tax)
- Risk Adjustment User Fee	\$	0.08	Exhibit F
- Reinsurance Contributions	\$	3.55	Exhibit F
- Licensing and Regulatory Fees	\$	20.79	Exhibit A (Line 13) x Exhibit G (Fees)
= <i>Estimated Federal MLR Denominator</i>	\$	447.36	

Estimated Federal MLR

81.85%

NOTES:

The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

{1} The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.

{2} Not all numerator/denominator components are captured above (for example, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).

{3} Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.

{4} Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule.

Exhibit N - Index Rate Development

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

1) Projected Paid Claim Cost	\$	372.63	Exhibit A, Line Item 8
2) <u>- Non-EHBs Embedded in Line Item 1) Above</u>	\$	0.90	
3) = Projected Paid Claims, Excluding ALL Non-EHBs	\$	371.73	
4) + Rx Rebates	\$	(6.76)	Exhibit E
5) <u>+ Additional EHBs {1}</u>	\$	2.06	Exhibit E
6) = Projected Paid Claims Reflecting only EHBs	\$	367.03	
7) <u>÷ Paid to Allowed Ratio</u>		0.72959	
8) = Projected Allowed Claims Reflecting only EHBs	\$	503.06	= Index Rate

NOTE:

{1} Pediatric Dental and Pediatric Vision

Exhibit O - Quarterly Index, Base, and Market Adjusted Index Rate Development

Anthem Insurance Companies, Inc. Small Group

	Rates Effective:				Member Weighted Average
	1Q15	2Q15	3Q15	4Q15	
Renewing Member Months	368,278	218,931	244,506	758,850	1,590,565
Quarterly Allowed Trend		2.47%	2.47%	2.47%	
Index Rate	\$ 503.06	\$ 515.48	\$ 528.21	\$ 541.26	\$ 526.86
Reinsurance Contribution	\$ 3.55	\$ 3.21	\$ 2.87	\$ 2.53	
Expected Reinsurance Payments	\$ -	\$ -	\$ -	\$ -	
Risk Adjustment Fee	\$ 0.08	\$ 0.08	\$ 0.08	\$ 0.08	
Risk Adjustment Net Transfer	\$ -	\$ -	\$ -	\$ -	
Exchange Fee	\$ 1.74	\$ 1.79	\$ 1.83	\$ 1.88	
Paid-to-allowed Ratio	0.72959	0.72959	0.72959	0.72959	
Market Adjusted Index Rate	\$ 510.43	\$ 522.44	\$ 534.76	\$ 547.40	\$ 533.46
Quarterly Premium Trend		2.47%	2.48%	2.49%	
Base Rate	\$ 349.92	\$ 358.56	\$ 367.46	\$ 376.61	\$ 366.54

NOTES:

{1} The 1Q15 index rate was derived in Exhibit N.

{2} The 1Q15 index rate is assumed to increase with quarterly allowed trend as illustrated above.

{3} The 1Q15 reinsurance and risk adjustment fees and payments are shown in Exhibit F. The reinsurance contribution for other effective dates is calculated by the same method shown in Exhibit F.

{4} Market Adjusted Index Rate = Index Rate + ((Reinsurance + Risk Adjustment Fee + Exchange Fee) ÷ Paid-to-allowed Ratio)

{5} The 1Q15 base rate was derived in Exhibit A.

{6} The 1Q15 base rate is assumed to increase with quarterly paid trend as illustrated above. This trend rate differs from the index rate trend in that it includes anticipated changes for non-EHBs, deductible leveraging, fees, and risk mitigation programs.

{7} Minor rate variances may occur due to differences in rounding methodology.

Exhibit P - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Small Group

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit O)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Adjust to 1Q15 eff date	Consumer Adjusted Premium Rate {4}
Anthem Bronze Blue Preferred X HMO 6000/30%/6600 Plus	17575IN0720010	\$533.46	0.6110	1.0000	1.0083	1.0000	\$109.21	\$437.85	1.4228	0.9547	\$293.79
Anthem Silver Blue Preferred X HMO 3000/20%/4500 Plus	17575IN0720008	\$533.46	0.7079	1.0000	1.0072	1.0000	\$126.41	\$506.74	1.4228	0.9547	\$340.01
Anthem Silver Blue Preferred X HMO 2000/30%/5500 Plus	17575IN0720009	\$533.46	0.7142	1.0000	1.0071	1.0000	\$127.60	\$511.32	1.4228	0.9547	\$343.08
Anthem Gold Blue Preferred X HMO 1250/10%/6350 Plus w/HSA	17575IN0720011	\$533.46	0.8045	1.0000	1.0063	1.0000	\$143.62	\$575.53	1.4228	0.9547	\$386.17
Anthem Bronze Blue Preferred X POS 6000/30%/6600 Plus	17575IN0730003	\$533.46	0.6110	1.0000	1.0083	1.0000	\$109.21	\$437.85	1.4228	0.9547	\$293.79
Anthem Bronze Blue Access PPO 5900/0%/6600 Plus	17575IN0740007	\$533.46	0.6323	1.0000	1.0112	1.0000	\$113.34	\$454.42	1.4228	0.9547	\$304.90
Anthem Bronze Blue Access PPO 5000/20%/6350 Plus w/HSA	17575IN0740010	\$533.46	0.5194	1.0000	1.0136	1.0000	\$93.40	\$374.26	1.4228	0.9547	\$251.12
Anthem Bronze Blue Access PPO 5000/50%/6350 Plus w/HSA	17575IN0740011	\$533.46	0.5049	1.0000	1.0140	1.0000	\$90.85	\$363.99	1.4228	0.9547	\$244.23
Anthem Bronze Blue Access PPO 4000E/20%/6350 w/HSA	17575IN0740025	\$533.46	0.6177	1.0000	1.0032	1.0000	\$109.90	\$440.49	1.4228	0.9547	\$295.56
Anthem Bronze Blue Access PPO 5500E/0%/5500 w/HSA	17575IN0740026	\$533.46	0.6296	1.0000	1.0032	1.0000	\$111.97	\$448.92	1.4228	0.9547	\$301.22
Anthem Bronze Blue Access PPO 3000/50%/6350 w/HSA	17575IN0740027	\$533.46	0.5661	1.0000	1.0035	1.0000	\$100.80	\$403.83	1.4228	0.9547	\$270.96
Anthem Bronze Blue Access PPO 6300/0%/6300 w/HSA	17575IN0740028	\$533.46	0.5515	1.0000	1.0036	1.0000	\$98.15	\$393.39	1.4228	0.9547	\$263.96
Anthem Bronze Blue Access PPO 4500/20%/6350 w/HSA	17575IN0740029	\$533.46	0.5583	1.0000	1.0036	1.0000	\$99.38	\$398.27	1.4228	0.9547	\$267.23
Anthem Bronze Blue Access PPO 5000E/20%/6350 w/HSA	17575IN0740030	\$533.46	0.5806	1.0000	1.0034	1.0000	\$103.33	\$414.14	1.4228	0.9547	\$277.88
Anthem Bronze Blue Access PPO 3500E/20%/6450 w/HSA	17575IN0740031	\$533.46	0.6322	1.0000	1.0031	1.0000	\$112.48	\$450.79	1.4228	0.9547	\$302.47
Anthem Bronze Blue Access PPO 4500E/0%/6350 w/HSA	17575IN0740032	\$533.46	0.6314	1.0000	1.0032	1.0000	\$112.31	\$450.22	1.4228	0.9547	\$302.09
Anthem Bronze Blue Access PPO 4500/30%/6350 w/HSA	17575IN0740033	\$533.46	0.5453	1.0000	1.0036	1.0000	\$97.09	\$389.08	1.4228	0.9547	\$261.06
Anthem Silver Blue Access PPO 2500/20%/6350 Plus	17575IN0740009	\$533.46	0.7040	1.0000	1.0101	1.0000	\$126.10	\$505.41	1.4228	0.9547	\$339.12
Anthem Silver Blue Access PPO 2000/30%/4500 Plus w/HSA	17575IN0740012	\$533.46	0.6743	1.0000	1.0105	1.0000	\$120.90	\$484.40	1.4228	0.9547	\$325.02
Anthem Silver Blue Access PPO 3000/0%/3000 Plus w/HSA	17575IN0740014	\$533.46	0.7260	1.0000	1.0098	1.0000	\$129.97	\$521.05	1.4228	0.9547	\$349.61
Anthem Silver Blue Access PPO 4000/20%/6600	17575IN0740021	\$533.46	0.6925	1.0000	1.0029	1.0000	\$123.12	\$493.58	1.4228	0.9547	\$331.18
Anthem Silver Blue Access PPO 5000/20%/6350	17575IN0740022	\$533.46	0.6683	1.0000	1.0030	1.0000	\$118.82	\$476.40	1.4228	0.9547	\$319.66
Anthem Silver Blue Access PPO 2000/50%/6350	17575IN0740023	\$533.46	0.7056	1.0000	1.0028	1.0000	\$125.53	\$503.02	1.4228	0.9547	\$337.52
Anthem Silver Blue Access PPO 5000/0%/6000	17575IN0740024	\$533.46	0.7024	1.0000	1.0028	1.0000	\$124.85	\$500.62	1.4228	0.9547	\$335.90
Anthem Silver Blue Access PPO 4000E/0%/5000 w/HSA	17575IN0740035	\$533.46	0.6764	1.0000	1.0029	1.0000	\$120.27	\$482.14	1.4228	0.9547	\$323.51
Anthem Silver Blue Access PPO 1500/20%/5000 w/HSA	17575IN0740036	\$533.46	0.7516	1.0000	1.0026	1.0000	\$133.69	\$535.69	1.4228	0.9547	\$359.44
Anthem Silver Blue Access PPO 2500/20%/4500 w/HSA	17575IN0740038	\$533.46	0.6882	1.0000	1.0029	1.0000	\$122.42	\$490.63	1.4228	0.9547	\$329.20
Anthem Silver Blue Access PPO 5500/0%/5500 w/HSA	17575IN0740039	\$533.46	0.5933	1.0000	1.0034	1.0000	\$105.55	\$423.13	1.4228	0.9547	\$283.91
Anthem Silver Blue Access PPO 3000E/0%/3000 w/HSA	17575IN0740040	\$533.46	0.7824	1.0000	1.0025	1.0000	\$139.03	\$557.45	1.4228	0.9547	\$374.04
Anthem Gold Blue Access PPO 1000/20%/3000 Plus	17575IN0740008	\$533.46	0.8440	1.0000	1.0084	1.0000	\$150.99	\$605.04	1.4228	0.9547	\$405.96
Anthem Gold Blue Access PPO 2000/0%/2000 Plus w/HSA	17575IN0740013	\$533.46	0.8242	1.0000	1.0086	1.0000	\$147.38	\$590.86	1.4228	0.9547	\$396.45
Anthem Gold Blue Access PPO 1500/30%/5000	17575IN0740015	\$533.46	0.8253	1.0000	1.0024	1.0000	\$146.72	\$588.08	1.4228	0.9547	\$394.59
Anthem Gold Blue Access PPO 3500/0%/4000	17575IN0740016	\$533.46	0.8358	1.0000	1.0024	1.0000	\$148.46	\$595.42	1.4228	0.9547	\$399.51
Anthem Gold Blue Access PPO 1500/30%/4000	17575IN0740017	\$533.46	0.8493	1.0000	1.0024	1.0000	\$150.96	\$605.10	1.4228	0.9547	\$406.01
Anthem Gold Blue Access PPO 2500/20%/4500	17575IN0740018	\$533.46	0.8128	1.0000	1.0024	1.0000	\$144.43	\$579.10	1.4228	0.9547	\$388.56
Anthem Gold Blue Access PPO 1000/20%/3500	17575IN0740019	\$533.46	0.8502	1.0000	1.0024	1.0000	\$151.18	\$605.79	1.4228	0.9547	\$406.47
Anthem Gold Blue Access PPO 1000/20%/5000	17575IN0740020	\$533.46	0.8757	1.0000	1.0023	1.0000	\$155.69	\$623.93	1.4228	0.9547	\$418.64
Anthem Gold Blue Access PPO 1250/10%/2250 w/HSA	17575IN0740034	\$533.46	0.8514	1.0000	1.0024	1.0000	\$151.35	\$606.60	1.4228	0.9547	\$407.02
Anthem Gold Blue Access PPO 2000/0%/2000 w/HSA	17575IN0740037	\$533.46	0.8572	1.0000	1.0023	1.0000	\$152.31	\$610.67	1.4228	0.9547	\$409.75

Notes:

{1} This adjustment assumes a healthier than average population will select the catastrophic plan. The catastrophic adjustment factor is normalized to 1.0 across all plans for revenue neutrality across the entire block.

{2} The Plan Adjusted Index Rate is calculated by multiplying the Market Adjusted Index Rate by the AV and cost sharing, provider network, benefits in addition to the EHBS, and catastrophic plan adjustments and then adding the administrative costs. The Plan Adjusted Index Rate can also be described as a Plan Level Required Premium.

{3} See Exhibit H - Calibration.

{4} The Consumer Adjusted Premium Rate is calculated by dividing the 'Plan Adjusted Index Rate' by the 'Calibration Factor' and then multiplying by the 'Adjust to 1Q15 effective date' factor.

Exhibit Q - Membership Projections for Cost-Sharing Reductions

Anthem Insurance Companies, Inc. Small Group

Rates Effective January 1, 2015

Silver Plan		Projected Membership by Subsidy Level:		
<u>HIOS Standard Component Plan ID</u>	<u>100-150%</u>	<u>150%-200%</u>	<u>200%-250%</u>	<u>Standard</u>
17575IN0720008	0	0	0	991
17575IN0720009	0	0	0	991
17575IN0740009	0	0	0	1,487
17575IN0740012	0	0	0	1,487
17575IN0740014	0	0	0	1,487
17575IN0740021	0	0	0	1,487
17575IN0740022	0	0	0	1,487
17575IN0740023	0	0	0	1,487
17575IN0740024	0	0	0	1,487
17575IN0740035	0	0	0	1,487
17575IN0740036	0	0	0	1,487
17575IN0740038	0	0	0	1,487
17575IN0740039	0	0	0	1,487
17575IN0740040	0	0	0	1,487

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

Anthem [Preferred] [Essential] [Core] [Gold] [Silver] [Bronze] Direct
Blue Access PPO [Copayment or Deductible/ Coinsurance/ Out-of-
Pocket Limits] [Plus] [w/ HSA]
[w/Dental] [/] [Vision] [w/[HRA] [/HSA]]



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

Anthem Insurance Companies, Inc.

[120 Monument Circle]
[Indianapolis, Indiana 46204]

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, [\[www.anthem.com\]](http://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, [\[www.anthem.com\]](http://www.anthem.com)

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, **provided that you request enrollment within 31 days after your other coverage ends if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).**

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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/doi

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

[Use with HSAs:

High-Deductible Health Plan for Use with Health Savings Accounts

This Plan is meant to be federally tax qualified and used with a qualified health savings account. Approval by the **Indiana Department of Insurance** does not guarantee tax qualification and this Plan has not been submitted for approval by the IRS. Please seek the advice of a tax advisor.]

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.


[President]

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] [Plan Year]
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment- Adding Members" section for further details

Deductible	In-Network	Out-of-Network
Per Member	\$0- \$6,400 \$1,000- \$6,300	\$1,000- \$12,000 \$2,000- \$12,600
Per Family [– Aggregate/ Delete for non-embedded CDHP plans: All other Members combined]	\$0- \$12,800 \$2,000- \$12,600	\$3,000- \$24,000 \$4,000- \$25,200
[Option for Non-Embedded Plans (CDHP): If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amounts apply to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amounts apply.]) The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible. [Option HRA funds cannot be used for services listed under “Dental Services for Members Age 19 and Older” or for services listed under “Vision Services for Members Age 19 and Older.”] [Deductible First HRA: Note: To meet the In-Network Deductible, your Plan will work as follows: Step 1 – Upfront In-Network Deductible — Members must pay a certain part of the In-Network Deductible listed above, [\$750– \$3,000] per Member] [and] [\$1,500– \$6,000] per Family], before using their HRA account. HRA funds cannot be used for this part of the Deductible (known as the “upfront” Deductible). Amounts paid toward the upfront Deductible will apply toward the annual In-Network Deductible. Step 2 – Health Reimbursement Account — After meeting the upfront Deductible, Members can use money in their HRA to help meet the rest of the annual In-Network Deductible. Step 3 – Traditional Health Coverage – Once the Annual In-Network Deductible has been met, coverage under this Plan begins.]		

Coinsurance	In-Network	Out-of-Network
Plan Pays	[100%-50%]	[70%-50%]
Member Pays	[0%-50%]	[30%-50%]
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	[\$2,000- \$6,350\$6,600]	[\$4,000- \$12,700\$4,500- \$15,750]
Per Family [Aggregate Delete for non-embedded CDHP plans: All other Members combined]	[\$4,000- \$12,700\$13,200]	[\$8,000- \$25,400 \$9,000- \$31,500]
[Option for Non-Embedded Plans: If you, the Subscriber, are the only person covered by this Plan, only the "per Member" amounts apply to you. If you also cover Dependents (other family members) under this Plan, only the "per Family" amounts apply.]		
[Standard for plans with deductible, coinsurance and copays: The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]		
[For plans that have deductible & coinsurance only, without copays: The Out-of-Pocket Limit includes all Deductibles and Coinsurance you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]		
The Out-of-Pocket Limit does not include amounts you pay for following benefits:		
• [Standard Option for embedded adult dental benefit / Do not use for HRA/HSA- Services listed under "Dental Services for Members Age 19 and Older"] • [Option for embedded adult vision benefit / Do not use for HRA/HSA: Services listed under "Vision Services for Members Age 19 and Older"] • Out-of-Network Human Organ and Tissue Transplant services.		
Once the Out-of- Pocket Limit is satisfied, you will not have to pay any additional [Use for plans with deductible, coinsurance and copays: Deductibles, Coinsurance, or Copayments] [Use for plans with deductible and coinsurance only: Deductibles or Coinsurance] for the rest of the Benefit Period [, except for the services listed above].		
The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water)	[\$100 Copayment] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Ambulance Services (Ground)	[\$100 Copayment] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	See "Mental Health and Substance Abuse Services."	
Cardiac Rehabilitation	See "Therapy Services."	
Chemotherapy	See "Therapy Services."	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services for Members Through Age 18		
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• Diagnostic and Preventive Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Basic Restorative Services	40% Coinsurance after Deductible	50% Coinsurance after Deductible
• Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Periodontal Services - Oral Surgery Services - Major Restorative Services - Prosthodontic Services - Dentally Necessary Orthodontic Care - Dentally Necessary Orthodontic Care Waiting Period	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 12 months
[Optional – Embedded Adult Dental: Dental Services for Members Age 19 and Older Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.]		
Each Member must pay a Deductible of \$50 per Benefit Period for the dental services below. [2014 Option: This Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan.]		
Diagnostic and Preventive Services	0% Coinsurance	50% Coinsurance
Basic Restorative Services	20% Coinsurance	60% Coinsurance
Endodontic Services	50% Coinsurance	75% Coinsurance
Periodontal Services	50% Coinsurance	75% Coinsurance
Oral Surgery Services	50% Coinsurance	75% Coinsurance
Major Restorative Services	50% Coinsurance	75% Coinsurance
Prosthodontic Services	50% Coinsurance	75% Coinsurance
Orthodontic Care	Not Covered	Not Covered
Dental Services for Members Age 19 and Older Benefit Maximum	\$1,000 per Benefit Period In- and Out-of-Network combined	
Dental Services (All Members / All Ages) Benefits are based on the setting in which Covered Services are received. Dental Services Accidental Injury Benefit Maximum \$3,000 per Accidental Injury, In- and Out-of-Network combined Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that We are required to cover by law.		

Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Wigs Needed After Cancer Treatment Benefit Maximum The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.	One wig per Benefit Period, In- and Out-of-Network combined	
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	[\$200- \$250] Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [Copayment waived if admitted]	
Emergency Room Doctor Charge	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		
Home Care		

Benefits	In-Network	Out-of-Network
Home Care Visits	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Dialysis	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Infusion Therapy	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Specialty Prescription Drugs	[\$10- \$50] Copayment] [per Drug] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Home Care Services / Supplies	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period, In- and Out-of-Network combined. The limit does not apply to Home Infusion Therapy or Home Dialysis.	
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period, In- and Out-of-Network combined 164 visits per Lifetime, In- and Out-of-Network combined	
Home Infusion Therapy	See "Home Care."	
Hospice Care		
- Home Care - Respite Hospital Stays	[No Copayment, Deductible, or Coinsurance] [0% Coinsurance] [no Deductible] [after Deductible]	[0%-50%] Coinsurance after Deductible
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	[\$250 - \$1,500] Copayment] [per admission] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors:		
Note: If you use a Preferred Hospital / Acute Care Facility you will pay a [\$125 - \$1,250] Copayment] [per admission] [plus] [0%-40%] Coinsurance] [no Deductible] [after Deductible]. [Please see [anthem.com] for a list of Preferred Facilities.]]		
Skilled Nursing Facility	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors:		
Note: If you use a Preferred Skilled Nursing Facility you will pay [0%- 40%] Coinsurance] [no Deductible] [after Deductible]. [Please see [anthem.com] for a list of Preferred Facilities.]]		
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period, In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[For plans with hospital copay:		
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.]		
[For plans with hospital copay:		
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.]		
Doctor Services for:		
General Medical Care / Evaluation and Management (E&M)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Surgery	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Maternity and Reproductive Health Services		
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal and delivery services)	[\$10- \$50] Copayment] [per pregnancy] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Use only when copays apply: If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.]	[Use only when OV copay applies: The Office Visit Copayment will also apply to the first prenatal visit.]	
Inpatient Services (Delivery)	See "Inpatient Services"	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services		
Inpatient Facility Services	[\$250- \$1,500] Copayment] [per admission] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Inpatient Facility you will pay [a [\$125- \$750] Copayment] per admission [plus] [0%- 50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Residential Treatment Center Services	[\$250- \$1,500] Copayment] [per admission] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Inpatient Doctor Services	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Outpatient Facility Services	[\$250 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [after Deductible] [no Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [a \$125 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Outpatient Doctor Services	[0%- 50%] Coinsurance] [No Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	[\$250 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendor Plans: Note: If you use a Preferred Partial Hospital/ Intensive Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Providers.]]		
Office Visits	[Covered in PCP / SCP Copayment] [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” in the “Additional Federal Notices” section for details.		
Occupational Therapy	See “Therapy Services.”	
Office Visits		
Primary Care Physician / Provider (PCP)	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[PC2: Note: If your PCP is part of our Patient-Centered Primary Enhanced Personal Health Care Program you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible].]		

Benefits	In-Network	Out-of-Network
Specialty Care Physician / Provider (SCP)	[\$20- \$60 \$75] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Retail Health Clinic Visit	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Retail Health Clinic you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Clinics.]]		
Online Visit	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible]
[Preferred Vendors: Note: If you use a Preferred Online Visit Provider you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Providers.]]		
Nutritional Counseling- includes Family Planning and Nutritional Counseling (Other than Eating Disorders)	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Nutritional Counseling for Eating Disorders	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Allergy Testing	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Shots/Injections (other than allergy serum)	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic Lab (non-preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic X-ray (non-preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic Tests (non-preventive; including hearing and EKG)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Office Surgery	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Therapy Services: - Chiropractic Care & Spinal Manipulation	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Physical, Speech, & Occupational Therapy	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Dialysis / Hemodialysis	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Cardiac Rehabilitation & Pulmonary Therapy	[\$20- \$60 \$75] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (includes allergy serum)	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Optional if 3 visits apply: Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.]		
Orthotics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Outpatient Facility Services		
• Facility Surgery Charge	[\$250 Copayment] [per visit] [plus] [0%- 50%] Coinsurance] [after Deductible] [no Deductible]]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [a \$125 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
• Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Doctor Surgery Charges	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Other Facility Charges (for procedure rooms or other ancillary services)	[\$250 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [a \$125 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
• Diagnostic Lab	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic X-ray	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[\$250 Copayment] [per service] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [a \$125 Copayment] [per service] [0%-50%] Coinsurance] [no Deductible] [after Deductible] for advanced diagnostic imaging services. [Please see anthem.com for a list of Preferred Facilities.]]		

Benefits	In-Network	Out-of-Network
- Therapy: - Chiropractic Care & Spinal Manipulation [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] - Physical, Speech, & Occupational Therapy [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] - Radiation / Chemotherapy / Non-Preventive Infusion & Injection [0%-50%] Coinsurance] [no Deductible] [after Deductible] - Dialysis / Hemodialysis [0%-50%] Coinsurance] [no Deductible] [after Deductible] - Cardiac Rehabilitation & Pulmonary Therapy [\$20- \$60 \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] See "Therapy Services" for details on Benefit Maximums. - Prescription Drugs Administered in an Outpatient Facility [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]		
Physical Therapy	See "Therapy Services."	
Preventive Care	No Copayment, Deductible, or Coinsurance	[30%-50%] Coinsurance after Deductible
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	

Benefits	In-Network	Out-of-Network
Pulmonary Therapy	See "Therapy Services."	
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See "Therapy Services."	
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	See "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received.	
[optional offer mandate – add when selected –Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime, In- and Out-of-Network combined]	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
- Physical Therapy - Occupational Therapy - Speech Therapy - Manipulation Therapy - Cardiac Rehabilitation	20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 36 visits per Benefit Period	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		

Benefits	In-Network	Out-of-Network
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	
Urgent Care Services (Office Visits)		
Urgent Care Office Visit Charge	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Testing	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Shots/ Injections (other than allergy serum)	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Office Surgery	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Vision Services for Members Through Age 18		
Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam	\$0 Copayment	Covered up to \$30
Limited to one exam per Benefit Period		
Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period every other calendar year. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Covered up to \$25
Bifocal	\$0 Copayment	Covered up to \$40
Trifocal	\$0 Copayment	Covered up to \$55
Progressive	\$0 Copayment	Covered up to \$40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost In-Network.		
Frames	\$0 Copayment	Covered up to \$45
Limited to one set of frames from the Anthem Formulary per Benefit Period every other calendar year.		
Contact Lenses		
Limited to one set of contact lenses from the Anthem formulary per Benefit Period every other calendar year. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Optional / Adult Embedded Vision Exam Plus Materials:		
Vision Services for Members Age 19 and Older		
Note: To get the In-Network benefit, you must use		

Benefits	In-Network	Out-of-Network
an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
• Routine Eye Exam Limited to one exam per Benefit Period.	\$20 Copayment	Covered up to \$30
• Standard Plastic Lenses Limited to one set of lenses [per Benefit Period] [every other calendar year]. Available only if the contact lenses benefit is not used.		
Single-Vision	\$20 Copayment	Covered up to \$25
Bifocal	\$20 Copayment	Covered up to \$40
Trifocal	\$20 Copayment	Covered up to \$55
Note: In-Network, lenses include factory scratch coating at no additional cost.		
• Frames Limited to one set of frames [per Benefit Period] [every other calendar year].	Covered up to \$130	Covered up to \$45
• Contact Lenses Limited to one set of contact lenses [per Benefit Period] [every other calendar year]. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	Covered up to \$80	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit. Benefits are based on the setting in which Covered Services are received.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this <i>before</i> you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further details.)		

Benefits	In-Network	Out-of-Network
The requirements described below do not apply to the following: • Cornea and kidney transplants, which are covered as any other surgery; and • Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service. Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.		
Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
• Precertification required	During the Transplant Benefit Period, [no Copayment / Deductible / Coinsurance.] [\$250-\$1,500] Copayment [per admission] [0% - 50% Coinsurance] [after Deductible] Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services,	During the Transplant Benefit Period, You will pay [30% -50%] Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also

Benefits	In-Network	Out-of-Network
	Home Visits, or Office Visits depending where the service is performed.	an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
Transportation and Lodging	[No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible] [Standard: No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30%-50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit. [30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.] [Option: Not covered]

Benefits	In-Network	Out-of-Network
Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant In- and Out-of-Network combined.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	[Standard: No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant, In- and Out-of-Network combined.	
Live Donor Health Services	[Standard: No Copayment/ Deductible/ Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. [Standard, but may remove for HRA/HSA plans that don't have copays: You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.]		
[Optional for Plans w/ Rx Deductible:		
Prescription Drug Deductible (Does not apply to Tier 1)		
[Per Member]	[\$250-\$500] In- and Out-of-Network combined]	
[Per Family]	[\$500- \$1,000] In- and Out-of-Network combined]	
[2014 Option: Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments/Coinsurance listed below.]		
[Optional for Plans w/ Rx OOP Limit:		
Prescription Drug Out-of-Pocket Limit		
[Per Member]	[\$6,350 In- and Out-of Network combined]	
[Per Family]	[\$12,700 In- and Out-of Network combined]	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
[2014 Option: Note: The Prescription Drug Out of Pocket Limit is separate and does not apply toward any other Out of Pocket Limit for Covered Services in this Plan. It includes all Deductibles, Coinsurance, and Copayments you pay for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy during a Benefit Period. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]		
[2014 Option if Separate Rx OOP: Once the Out of Pocket Limit is satisfied, you will not have to pay an additional Deductibles, Coinsurance, or Copayments for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy for the rest of the Benefit Period.]		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)		30 days
Home Delivery (Mail Order) Pharmacy		90 days
Specialty Pharmacy (In-Network and Out-of-Network)		30 days*
	*See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
[Use for HSA Plans: Note: The Prescription Drug Copayments listed below will not apply until after the Plan Deductible is met.]		
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$10- \$15] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 2 Prescription Drugs	[\$30- \$50] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 3 Prescription Drugs	[\$60- \$90] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 4 Prescription Drugs	[0%-50%] Coinsurance [to a maximum of [\$250- \$500] [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$25- \$38] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 2 Prescription Drugs	[\$75- \$125] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered
Tier 3 Prescription Drugs	[\$150- \$225] Copayment] [0%-50%] Coinsurance] [after Deductible] per Prescription Drug	Not covered
Tier 4 Prescription Drugs	[0%-50%] Coinsurance] [to a maximum of [\$250- \$500] [after Deductible] per Prescription Drug	Not covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.		
[OPTIONAL-Brand Penalty: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.] [Regular PPO plans: Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.] [HSA plans: Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]		
Orally Administered Cancer Chemotherapy	[Use with all regular plans: No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network. No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-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.]	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
[Use with HSA RX copay plans: After Deductible has been satisfied, no Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network. After Deductible has been satisfied, you get from an Out-of-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.] [Use with HSA coinsurance plans: Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from an In-Network Pharmacy, Home Delivery Pharmacy, Specialty Pharmacy Network, or Non-Network Pharmacy.] 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.		

How Your Plan Works

Introduction

Your Plan is a PPO plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

[PC2 option:

Patient-Centered Primary Care Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Patient-Centered Primary Care Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

Crediting Prior Plan Coverage

If you were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Group offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- **Your Group moves to this Plan at the beginning of a Benefit Period;**
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard® Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard®." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need health care, as long as you use a BlueCard® Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

In a non-Emergency situation, you can find the nearest contracted Provider by visiting the BlueCard® Doctor and Hospital Finder website [www.BCBS.com] or call the number on the back of your Identification Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard® program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard® Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard® Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard® Worldwide.

Payment Details

- **Participating BlueCard® Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard® Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard® Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard® Worldwide Service Center. Then you can fill out a BlueCard® Worldwide claim form and send it with the original bill(s) to the BlueCard® Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard® Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard® Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard® Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by a BlueCard®/Out-of-Network/Non-Participating Provider
Provider	- Member must get Precertification. - If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. - For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

[2015 Update for Fraud & Balance Billing Program per Legal:] We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Request Categories

- **Emergent Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review**- A request for Precertification or Predetermination that is conducted during the course of **outpatient** treatment or **during an Inpatient** admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective EmergentUrgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non- EmergentUrgent	2 business days from the receipt of the request
Continued Stay Review Emergent-Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent-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
Continued Stay Review Non- EmergentUrgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	
Prospective EmergentUrgent	72 hours from the receipt of request
Prospective Non- EmergentUrgent	15 calendar days from the receipt of the request
Continued Stay Review Emergent-Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request

Continued Stay Review Emergent 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
Continued Stay Review Non- Emergent Urgent	15 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed.

For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a **covered benefit** **Covered Service** under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management **Program** **program** to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving. **These programs are given at no extra cost to you.**

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your **chosen authorized** representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your **authorized** representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for more important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See “Mental Health and Substance Abuse Services” later in this section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

~~Option—Embedded Dental (Pediatric &/or Adult)~~ Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

~~This Plan covers a preset schedule of dental services without a review for Medical Necessity.~~
[Ortho/Dental Necessity Option: When orthodontic care is covered by this Plan, claims will be reviewed to determine if it was Dentally Necessary orthodontic care. See the "Orthodontic Care" benefit for more information.]

~~Your dentist may recommend dental care services that are not covered, are cosmetic in nature, or exceed the benefit maximums of this Plan. While these services may be Medically Necessary for your condition, they may not be covered by this Plan. There may be other dental services available that are covered. These other services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the dental service recommended by your dentist. You will have to pay for any costs that exceed the allowance, in addition to any Deductible, Copayments, or Coinsurance you may have.~~

~~The decision as to what dental care treatment is best for you is solely between you and your dentist.~~

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedure codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

A pretreatment estimate is a valuable tool for you and your dentist. It gives you and the dentist an idea of what your out of pocket costs will be. This allows you and your dentist to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but not required, for you to get benefits for Covered Services.

A pretreatment estimate does not authorize treatment or determine its Medical or Dental Necessity [Ortho / Dental Necessity option: (except for orthodontics)], and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is sent to us. This is an estimate only. Our final payment will be based on the claim that is sent to us at the time of the completed dental care service(s). Sending in other claims or changes to your eligibility or to this Plan may affect our final payment.

You can ask your dentist to send in a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can give these to you). Pretreatment estimate requests can be sent to Anthem Blue Cross and Blue Shield. If you have questions on where to send the estimate, call us at the number on the back of your ID card.

[Option — Embedded Pediatric Dental: Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18 when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, the Plan will cover the least expensive treatment.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s) – 4 single x-rays per 12-month period.
- Occlusal – 2 series per 24-month period.
- Vertical- Covered at 1 series (7 to 8) of bitewings per 6 month period.

Interpretation of diagnostic images by a practitioner not associated with capture of the image, including report.

Dental Cleaning (Prophylaxis)- Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per 12-month period calendar year.

Fluoride Varnish Covered 2 times per 12-month period calendar year.

Sealants or Preventive Resin Restorations Any combination of these procedures is covered once per 36-month period for permanent first and second molars.

Space Maintainers.

Recent Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Emergency Treatment for the temporary relief of pain or infection.

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Benefits for amalgam or composite restorations will be limited to one service per tooth per 24-month period.

Recent inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth)- Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention- per tooth, in addition to restoration.

Space Maintainers Covered once per lifetime for extracted primary posterior (back) teeth.

Resement Space Maintainer

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy– Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy- If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

All of the above endodontic services are limited to once per tooth per lifetime.

Other Endodontic Treatments Limited to once per tooth per lifetime:

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal)- not including root canal therapy
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per calendar year 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement. **is covered once per lifetime.**

Crown Lengthening **Covered once per lifetime.**

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single **tooth; or** multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.
- Only one complex surgical periodontal service is covered per 36-month period for multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures **Covered only when required to prepare for dentures and limited to once in a 60-month period.**

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision **or of** pericoronal gingiva

- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- **Surgical access of unerupted tooth**
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia ~~Covered only when given with covered complex surgical services.~~

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

~~Pre-fabricated or Stainless Steel Crown Covered once per 60-month period.~~

Onlays and/or Permanent Crowns Covered once every ~~5 years~~**60 months** if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recent Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair ~~Covered once per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.~~ Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every ~~5 years~~**60 months** when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

~~Resin infiltration/smooth surface~~

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning ~~Covered once per 24-month period.~~

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered ~~once per 12-month period~~ when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

| **Denture Adjustments** Covered **2 times per 12 month period** when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

| **Partial and Bridge Adjustments** Covered **2 times per 24 month period** when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

| **Removable Prosthetic Services (Dentures and Partials)** Covered once **per 5 year period** every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

| **Fixed Prosthetic Services (Bridge)** Covered once every **5 years** 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

| **Recent Fixed Prosthetic** **Covered once per 12 months.**

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. **[Ortho / Dental Necessity option:** We will only cover Dentally Necessary orthodontic care. To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or

Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.】

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum

Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.]

[Optional embedded adult dental benefit: Dental Services For Members Age 19 and Older]

This Plan covers the dental services below for Members age 19 and older when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, the Plan will cover the least expensive treatment.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- Bitewings – 1 series per 24-month period.
- Full Mouth (Complete Series) or Panoramic – Once per 60-month period.
- Periapical(s) – 4 single x-rays per 12-month period.
- Occlusal – 2 series per 24-month period.

Dental Cleaning (Prophylaxis) Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth. Any combination of this procedure and periodontal maintenance (See "Periodontal Services" below) are covered 2 times per calendar year.

Basic Restorative Services

Emergency Treatment Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- Anterior (front) Teeth – Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior (back) Teeth – Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Benefits will be limited to the same surfaces and allowances for amalgam (silver filling). You must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and the optional treatment plus any Deductible and/or Coinsurance.

Benefits for amalgam or composite restorations will be limited to one service per tooth surface per 24-month period.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Brush Biopsy – Covered once per 36-month period for Members age 20 to 39. Covered once per 12-month period for Members age 40 and older.

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy
- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

All of the above endodontic services are limited to once per tooth per lifetime.

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 2 times per calendar year.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered once per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- Full-mouth debridement is covered once per lifetime.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge – Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single tooth; or
- Only one complex surgical periodontal service is covered per 36-month period for multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removals of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures Covered only when required to prepare for dentures and limited to once in a 60-month period:

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Surgical Reduction of Fibrous Tuberosity Covered once every 6 months.

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia — Covered only when given with covered complex surgical services. Benefits are not available when given with non-surgical dental care.

Major Restorative Services

Gold foil restorations The Plan will cover an amalgam (silver filling) benefit equal to the same number of surfaces and allowances.

You must pay the difference in cost between the Maximum Allowed Amount for the Covered Services and optional treatment plus any Deductible and/or Coinsurance that applies. Covered once per 24-month period.

Inlays Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 7 years if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance that applies.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered once per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.

Restorative cast post and core build up, including 1 post per tooth and 1 pin per surface Covered once every 7 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prosthodontic Services

Tissue Conditioning Covered once per 24-month period.

Reline and Rebase Covered once per 24-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge);

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered once per 6-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered 2 times per 12-month period when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered 2 times per 24-month period when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once per 7 year period:

- For the replacement of extracted (removed) permanent teeth;
- If 7 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 7 years:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 7 years;
- If 7 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. — Any optional benefits are subject to all contract limits on the Covered Service.

Recent Fixed Prosthetic Covered once per 12 months.

Single Tooth Implant Body, Abutment and Crown Covered once per 7 year period. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self-management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;

- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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 layperson who possesses an average knowledge of health and medicine to: (a) place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means 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.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** has been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

| Non-Covered **benefits Services** for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.

- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Optional: Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.]

[Optional: Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.]

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape. **[Standard: The Plan will also cover elective abortions.]** Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification, and rehabilitation.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital and office visits or outpatient Facility, such as partial hospitalization and intensive outpatient programs.
- **Day Treatment Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care" benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in “Urgent Care Services” later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care is given during an office visit or as an outpatient. Screenings includes screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the “Diagnostic Services” benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women’s contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”]
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per [Standard: pregnancy] [Benefit Period].
 - c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government’s web sites,

<http://www.healthcare.gov/center/regulations/prevention.html>, <http://www.healthcare.gov/center/regulations/prevention.html#what-are-my-preventive-care-benefits>, <http://www.ahrq.gov/clinic/uspstfix.htm>, and <http://www.cdc.gov/vaccines/acip/index.html#recs/acip/>.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” later in this booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services (All Members/All Ages)" section.

- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

[Include when embedded pediatric dental benefit is included:] Your Plan also covers certain oral surgeries for children. Please refer to “Dental Services for Members Through Age 18” for details.]

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.

- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See "Human Organ and Tissue Transplant" earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit.

Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services for Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In-Network.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.

- When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglass lenses until the next Benefit Period. If you choose eyeglass lenses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Optional / Embedded Adult Coverage: Vision Services for Members Age 19 and Older

The vision benefits described in this section only apply to Members age 19 or older.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Lens benefits include factory scratch coating.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)

Frames

A selection of frames is covered under this Plan. Members will get a benefit allowance toward the purchase of any frame. If the frame you choose costs more than the Plan's allowance, you will have to pay the amount over the Plan's allowance.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses — Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses — Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses;
 - High Ametropia exceeding -12D or +9D in spherical equivalent;
 - Anisometropia of 3D or more;
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglass lenses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- **[Standard unless opt out allowed due to religious beliefs:** Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- **Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.**
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.

- FDA approved smoking cessation products including over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;

- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs. This tier contains higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

[Standard for all plans except HRA/HSA: Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.]

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for ~~option:~~ elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details.

This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a Doctor.
- 2) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
- 3) **Administrative Charges**
 - a) Charges to complete claim forms,
 - b) Charges to get medical records or reports,
 - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - a. Acupuncture,
 - b. Holistic medicine,
 - c. Homeopathic medicine,
 - d. Hypnosis,
 - e. Aroma therapy,
 - f. Massage and massage therapy,
 - g. Reiki therapy,
 - h. Herbal, vitamin or dietary products or therapies,
 - i. Naturopathy,
 - j. Thermography,
 - k. Orthomolecular therapy,
 - l. Contact reflex analysis,
 - m. Bioenergetic synchronization technique (BEST),
 - n. Iridology-study of the iris,
 - o. Auditory integration therapy (AIT),
 - p. Colonic irrigation,
 - q. Magnetic innervation therapy,
 - r. Electromagnetic therapy.

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Certain Providers** ~~Services you get from a non-covered Provider, as defined in this Booklet. Service you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet.~~ Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. ~~This Exclusion does not apply if you were the victim of a crime, including domestic violence. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.~~
- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

[Include when pediatric and/or adult dental benefit is embedded in plan:

15) Dental Services

- a) Dental care for Members age 19 or older.
- b) Dental services not listed as covered in this Booklet.
- c) Oral hygiene instructions.
- d) Case presentations.
- e) Athletic mouth guards, enamel microabrasion and odontoplasty.
- f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- h) Pulp vitality tests.
- i) Adjunctive diagnostic tests.

- j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- n) Incomplete root canals.
- o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
- p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- q) Provisional splinting, temporary procedures or interim stabilization.
- r) Services of anesthesiologists, unless required by law.
- s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- w) Canal prep & fitting of preformed dowel & post.
- x) Temporary, provisional or interim crown.
- y) Occlusal procedures.
- z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- aa) Pin retention is not covered when billed separately from restoration procedure.
- bb) Services for the replacement of an existing partial denture with a bridge.
- cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- ee) Separate services billed when they are an inherent component of another covered service.
- ff) Cone beam images.
- gg) Anatomical crown exposure.
- hh) Temporary anchorage devices.
- ii) Sinus augmentation.
- jj) Repair or replacement of lost/broken appliances.

[Include for adult dental embedded coverage:

kk) Any material grafted onto bone or soft tissue, including procedures necessary to guided tissue regeneration;

ll) Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a covered person under this Plan. This Exclusion will not apply for any Member who has been continuously covered for more than 24 months;

mm) For Members age 19 and older, corrections of congenital conditions during the first 24 months of continuous coverage under this Plan;

nn) Dental implant maintenance or repair to an implant or implant abutment;

oo) Orthodontic care for Members age 19 and older.}]

[Delete when pediatric and/or adult dental benefit is embedded in plan:

16) Dental Treatment Dental treatment, except as listed below:

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;
- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded.

This Exclusion does not apply to services that we must cover by law.]

17)16) Educational Services Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

18)17) Experimental or Investigational Services Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the criteria we use to determine if a Service is Experimental or Investigational is outlined below.

19)18) Eyeglasses and Contact Lenses Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

20)19) Eye Exercises Orthoptics and vision therapy.

21)20) Eye Surgery Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

22)21) Family Members Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

23)22) Foot Care Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

- a) Cleaning and soaking the feet.
- b) Applying skin creams to care for skin tone.
- c) Other services that are given when there is not an illness, injury or symptom involving the foot.

24)23) Foot Orthotics Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.

- | ~~25)~~24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- | ~~26)~~25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers' Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- | ~~27)~~26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- | ~~28)~~27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- | ~~29)~~28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- | ~~30)~~29) **Infertility Treatment** Testing or treatment related to infertility.
- | ~~31)~~30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- | ~~32)~~31) **Medical Equipment and Supplies**
 - a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
- | ~~33)~~32) **Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- | ~~34)~~33) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- | ~~35)~~34) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- | ~~36)~~35) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- | ~~37)~~36) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- | ~~38)~~37) **Personal Care and Convenience**
 - a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

- b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
- c) Home workout or therapy equipment, including treadmills and home gyms,
- d) Pools, whirlpools, spas, or hydrotherapy equipment.
- e) Hypo-allergenic pillows, mattresses, or waterbeds,
- f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

39)38) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.

40)39) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

41) **Certain Providers** Services you get from a non-covered Provider, as defined in this Booklet. Service you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

Comment [r1]: Moved for alph order

42) **Residential Treatment Centers** Unless we must cover them by law.

43)40) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.

44)41) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

45)42) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.

46)43) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

47)44) **[Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]

48)45) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

49)46) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

50)47) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

51)48) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

[Option – Embedded pediatric and/or adult vision:

52)49) **Vision Services**

a) **[Include if only pediatric vision is covered:]** Vision services for Members age 19 or older, unless listed as covered in this Booklet.]

b) **[Include if adult vision is covered but limited to exam-only option: Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.]**

e)b) Safety glasses and accompanying frames.

d)c) For two pairs of glasses in lieu of bifocals.

e)d) Plano lenses (lenses that have no refractive power).

- f) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
- g) Vision services not listed as covered in this Booklet.
- h) Cosmetic lenses or options.
- i) Blended lenses.
- j) Oversize lenses.
- k) Sunglasses and accompanying frames.
- l) For services or supplies combined with any other offer, coupon or in-store advertisement.
- m) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
- n) Certain frames in which the manufacturer imposes a no discount policy.

~~When vision services carved out to stand-alone plan:~~

~~53) Vision Services Vision services not described as Covered Services in this Booklet.~~

- 54) 50) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover Bariatric Surgery per mandate option: This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

- 55) 51) **[Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgeries that reduce stomach size), or gastric banding procedures.]

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **[Optional non-standard: Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your Doctor believes you need to keep using a certain Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.]

3. **Compound Drugs** ~~Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product~~

Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.

[Religious group opt out to exclude Contraceptive drugs:]

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the **"Prescription Drugs Administered by a Medical Provider"** section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments. ~~Include only if pediatric dental is embedded:~~ While these services are not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they may be covered under the "Dental Services for Members Through Age 18" benefit. Please see that section for further details.†
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
15. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these may be covered under the "Allergy Services" benefit. Please see that section for details.
16. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

18. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one or more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "[Out-of-Area Services](#)" and "[Inter-Plan Programs](#)" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total out of pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*

- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.
- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of \$1500, or \$450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is \$500, you may receive a bill from the Out-of-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your In-Network Copayment of \$25, your total out of pocket expense would be \$325.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including

if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem's Service Area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare Providers. Anthem's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside Anthem's Service Area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When covered healthcare services are provided outside of our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. An Out-of-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 [(carve-out) Medicare.] 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 generally 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.

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.

"Recovery" means is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Your Member Rights and Responsibilities as an Anthem Blue Cross and Blue Shield Member

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.

- Follow the care plan that you have agreed on with your Doctors or health care Providers.
- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card

As an Anthem Blue-Cross and Blue Shield (Anthem) Member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights" and helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care Providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your Plan and in the way your Plan works.
- Make a complaint or file an appeal about:
 - Your Plan
 - Any care you get
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Participate in matters that deal with our policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any Primary Care Physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.

- * To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
 - * Follow the care plan that you have agreed on with your doctors or health care professionals.
 - * Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
 - * Follow all Plan rules and policies.
 - * Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.
 - * Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.
- For details about your coverage and benefits, please read the rest of this Booklet.

~~We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.~~

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

Definitions

"Appeal" means 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.

"Expedited Review" means 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" means 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 Booklet.

"Grievance" means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-317-287-5968/800-368-3238] if you wish to file your Grievance by fax.

{For "Dental Benefits for Members Through Age 18" Issues:}

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 551122
Minneapolis, Minnesota
53400-0551/55440-1122]

For "Vision Benefits for Members Through Age 18" [or "Vision Benefits for Members Age 19 or Older"] Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3-five (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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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
- 4.3. The service is not specifically excluded in this Booklet.

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 not received by us after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the 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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse, ~~as recognized under the laws of the state where the Subscriber lives.~~ For information on spousal eligibility please contact the Group.
- **[Domestic partner coverage:** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who **[Standard only when affidavit used:** has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard only when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstance:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Plan unless required by the laws of this state.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- ~~Subscriber and one child;~~
- Subscriber and child(ren);
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during [Standard: an Open Enrollment period or during] a Special Enrollment period [Optional: or as a Late Enrollee], as described below.

[Standard / Open Enrollment: Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [**Standard:** prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium **for contribution to premium** or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- **Lost employer contributions towards the cost of the other coverage;**
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they may apply for coverage at any time during the year as a Late Enrollee. [Standard: However, you will not be eligible to enroll until the next Open Enrollment Period.]

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying Us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Dependents:</u> A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave. Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against [Anthem] based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/ Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives

such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

We may offer health or fitness related program options for purchase by your Group. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed and could be discontinued at any time. If your Group has selected one of these options, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors when administered according to state or federal law. However, if it is unreasonably difficult due to a medical condition for you to achieve the standards for a reward under such a program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive gift cards and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "Benefits After Termination."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits " for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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 "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

[Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.]

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does **not** include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

~~The most you pay during a Benefit Period for Covered Services before your Plan begins benefits. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Schedule of Benefits" for details.~~

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Predetermination

Please see the section "Getting Approval for Benefits " for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- ~~2) Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.~~
- 3) Insulin, diabetic supplies, and syringes.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

~~A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Covered Providers are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.~~

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by state regulatory agencies.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

Anthem [Gold][Silver][Bronze] Blue Preferred [on exchange only: X] HMO
[Insert INN Cost Share: Copay or Deductible / Coinsurance / OOP
Limit] [Plus] [w/HSA]

Anthem [Gold][Silver][Bronze] DirectAccess [Plus][w/HSA]



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

[on-exchange only: If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.]

Anthem Insurance Companies, Inc.

[120 Monument Circle]
[Indianapolis, Indiana 46204]

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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, [\[www.anthem.com\]](http://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, following a pre-approved treatment plan, or procedures for making referrals. 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, [\[www.anthem.com\]](http://www.anthem.com)

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

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The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

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In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

[Use with HSAs:

High-Deductible Health Plan for Use with Health Savings Accounts

This Plan is meant to be federally tax qualified and used with a qualified health savings account. Approval by the **Indiana Department of Insurance** does not guarantee tax qualification and this Plan has not been submitted for approval by the IRS. Please seek the advice of a tax advisor.]

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.


[

President]

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, Urgent Care, or Authorized Services. Please be sure to contact us if you are not sure if we have approved an Authorized Service. Benefits are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an approved Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for additional details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] [off-exchange only; Plan Year]
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

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Deductible	In-Network
[Per Member]	[\$1,250-5,000] \$6,000
[Per Family Delete for non-embedded HSA plans – All other Members combined]]	[\$2,500-10,000] \$12,000
[Option for Non-Embedded HSA Plans: If you, the Subscriber, are the only person covered by this Plan, only the "per Member" amount applies to you. If you also cover Dependents (other family members) under this Plan, only the "per Family" amount applies.]] When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.	

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Coinsurance	In-Network
Plan Pays	[90%-70%]
Member Pays	[10%-30%]
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an approved Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.	

Out-of-Pocket Limit	In-Network
[Per Member]	[\$4,500-6,350] \$6,600
[Per Family Delete for Non-Embedded HSA Plans – All other Members combined]]	[\$9,000-\$12,700] \$13,200
[Option for Non-Embedded HSA Plans: If you, the Subscriber, are the only person covered by this Plan, only the "per Member" amount applies to you. If you also cover Dependents (other family members) under this Plan, only the "per Family" amount applies.]] The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or charges for non-Covered Services. -Once the Out-of- Pocket Limit is satisfied, you will not have to pay additional [Deductibles or Coinsurance][Deductibles, Coinsurance, or Copayments] for the rest of the Benefit Period, except for the services listed above.	

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Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the

right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Ambulance Services (Air and Water)	[10%-30%] Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Ambulance Services (Ground)	[10%-30%] Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	Not Covered
Behavioral Health Services	See "Mental Health and Substance Abuse Services."	Not covered
Cardiac Rehabilitation	See "Therapy Services."	Not covered
Chemotherapy	See "Therapy Services."	Not covered

Benefits	In-Network	Out-of-Network
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	Not covered
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	Not covered
Dental Services Accidental Injury Benefit Maximum	\$3,000 per Accidental Injury	Not covered
Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that we are required to cover by law.		
Dental Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• Diagnostic and Preventive Services	10% Coinsurance after Deductible	Not covered
• Basic Restorative Services	40% Coinsurance after Deductible	Not covered
• Endodontic Services	50% Coinsurance after Deductible	Not covered
• Periodontal Services	50% Coinsurance after Deductible	Not covered
• Oral Surgery Services	50% Coinsurance after Deductible	Not covered
• Major Restorative Services	50% Coinsurance after Deductible	Not covered
• Prosthodontic Services	50% Coinsurance after Deductible	Not covered
• Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	Not covered
Dentally Necessary Orthodontic Care Waiting Period	12 months	Not covered

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Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	Not covered
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	Not covered
[Optional/not for HSAs - Note: If you use a Preferred Diagnostic Lab (i.e., reference labs), you may not have to pay a Copayment, Deductible, or Coinsurance. Please see anthem.com for a list of these labs.]		
Dialysis	See "Therapy Services."	Not covered
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	[10%-30%] Coinsurance after Deductible	Not covered
Wigs Needed After Cancer Treatment Benefit Maximum One wig per Benefit Period The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.	Not covered	
Emergency Room Services Emergency Room - Emergency Room Facility Charge [\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [Copayment waived if admitted] - Emergency Room Doctor Charge [10%-30%] Coinsurance after Deductible		

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Benefits	In-Network	Out-of-Network
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	[10%-30%] Coinsurance after Deductible	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible	
Home Care		
Home Care Visits	[10%-30%] Coinsurance after Deductible	Not covered
Home Dialysis	[10%-30%] Coinsurance after Deductible	Not covered
Home Infusion Therapy	[10%-30%] Coinsurance after Deductible	Not covered
Specialty Prescription Drugs	[10%-30%] Coinsurance after Deductible	Not covered
Other Home Care Services / Supplies	[10%-30%] Coinsurance after Deductible	Not covered
Home Care Benefit Maximum	100 visits per Benefit Period The limit does not apply to Home Infusion Therapy or Home Dialysis.	Not covered
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period 164 visits per Lifetime	Not covered
Home Infusion Therapy		
	See "Home Care."	Not covered
Hospice Care		
- Home Care - Respite Hospital Stays	0% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	Not covered
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
• Skilled Nursing Facility	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period	Not covered
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	[10%-30%] Coinsurance after Deductible	Not covered
[For plans with hospital copay: Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.]		
[For plans with hospital copay: Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.]		
Doctor Services for:		
• General Medical Care / Evaluation and Management (E&M)	[10%-30%] Coinsurance after Deductible	Not covered
• Surgery	[10%-30%] Coinsurance after Deductible	Not covered
Maternity and Reproductive Health Services		

Benefits	In-Network	Out-of-Network
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	[10%-30%] Coinsurance after Deductible	Not covered
If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.	[Use only when office visit copay applies: The Office Visit Copayment will also apply to the first prenatal visit.]	
Inpatient Services (Delivery)	See "Inpatient Services"	Not covered
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services		
Inpatient Facility Services	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Residential Treatment Center Services	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not Covered
Inpatient Doctor Services	[10%-30%] Coinsurance after Deductible	Not covered
Outpatient Facility Services	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
Outpatient Doctor Services	[10%-30%] Coinsurance after Deductible	Not covered
Partial Hospitalization Program / Intensive Outpatient Services	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
Office Visits	[\$30-35] Copayment per visit for the first [3] visits, then] [10%-30%] Coinsurance after Deductible	Not covered
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.		
Occupational Therapy	See "Therapy Services."	Not covered

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Benefits	In-Network	Out-of-Network
Office Visits		
• Primary Care Physician / Provider (PCP)	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Specialty Care Physician / Provider (SCP)	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Retail Health Clinic Visit	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Online Visit	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Nutritional Counseling - Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	[10%-30%] Coinsurance after Deductible	Not covered
• Nutritional Counseling for Eating Disorders	[10%-30%] Coinsurance after Deductible	Not covered
• Allergy Testing	[10%-30%] Coinsurance after Deductible	Not covered
• Allergy Shots / Injections (other than allergy serum)	[10%-30%] Coinsurance after Deductible	Not covered
• Preferred Diagnostic Labs (i.e., reference labs)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Lab (non-preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic X-ray (non-preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Tests (non-preventive; including hearing and EKG)	[10%-30%] Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible	Not covered
• Office Surgery	[10%-30%] Coinsurance after Deductible	Not covered
• Therapy Services:		Not covered
• -- Chiropractic Care & Spinal Manipulation	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered

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Benefits	In-Network	Out-of-Network
- Physical, Speech, & Occupational Therapy	[\$30-35] Copayment per visit for the first 3 visits, then [10%-30%] Coinsurance after Deductible	Not covered
- Dialysis / Hemodialysis	[10%-30%] Coinsurance after Deductible	Not covered
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	[10%-30%] Coinsurance after Deductible	Not covered
- Cardiac Rehabilitation & Pulmonary Therapy	[\$30-35] Copayment per visit for the first 3 visits, then [10%-30%] Coinsurance after Deductible	Not covered
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (includes allergy serum)	[10%-30%] Coinsurance after Deductible	Not covered
[Not for use with coinsurance only plans or HSA plans: Important Note on Office Visit Copayments: Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.]		
Orthotics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	Not covered
Outpatient Facility Services		
• Facility Surgery Charge	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
• Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	[10%-30%] Coinsurance after Deductible	Not covered
• Doctor Surgery Charges	[10%-30%] Coinsurance after Deductible	Not covered
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	[10%-30%] Coinsurance after Deductible	Not covered

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Benefits	In-Network	Out-of-Network
• Other Facility Charges (for procedure rooms or other ancillary services)	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Lab	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic X-ray	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
• Therapy:		
a- Chiropractic Care & Spinal Manipulation	[10%-30%] Coinsurance after Deductible	Not covered
b- Physical, Speech, & Occupational	[10%-30%] Coinsurance after Deductible	Not covered
c- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	[10%-30%] Coinsurance after Deductible	Not covered
d- Dialysis / Hemodialysis	[10%-30%] Coinsurance after Deductible	Not covered
e- Cardiac Rehabilitation & Pulmonary Therapy	[10%-30%] Coinsurance after Deductible	Not covered
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in an Outpatient Facility	[10%-30%] Coinsurance after Deductible	Not covered
Physical Therapy	See "Therapy Services."	Not covered
Preventive Care	No Copayment, Deductible, or Coinsurance	Not covered

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Benefits	In-Network	Out-of-Network
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	Not covered
Pulmonary Therapy	See "Therapy Services."	Not covered
Radiation Therapy	See "Therapy Services."	Not covered
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Respiratory Therapy	See "Therapy Services."	Not covered
Skilled Nursing Facility	See "Inpatient Services."	Not covered
Speech Therapy	See "Therapy Services."	Not covered
Surgery	Benefits are based on the setting in which Covered Services are received.	Not covered
[<i>optional offer mandate – add when selected</i>] Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime]	Not covered
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	Not covered
Therapy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Benefit Maximum(s):	Benefit Maximum(s) are for office and outpatient visits combined.	Not covered
Physical Therapy	20 visits per Benefit Period	Not covered

Benefits	In-Network	Out-of-Network
• Occupational Therapy	20 visits per Benefit Period	Not covered
• Speech Therapy	20 visits per Benefit Period	Not covered
• Manipulation Therapy	20 visits per Benefit Period	Not covered
• Cardiac Rehabilitation	36 visits per Benefit Period	Not covered
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	Not covered
Urgent Care Services (Office Visit)		
• Urgent Care Office Visit Charge	[10%-30%] Coinsurance after Deductible	
• Allergy Testing	[10%-30%] Coinsurance after Deductible	
• Allergy Shots / Injections (other than allergy serum)	[10%-30%] Coinsurance after Deductible	
• Preferred Diagnostic Labs (i.e., reference labs)	[10%-30%] Coinsurance after Deductible	
• Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	[10%-30%] Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible	
• Office Surgery	[10%-30%] Coinsurance after Deductible	
• Prescription Drugs Administered in the Office (includes allergy serum)	[10%-30%] Coinsurance after Deductible	

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Benefits	In-Network	Out-of-Network
If you see an Out-of-Network Provider, that Provider may also bill you for any charges over the Plan's Maximum Allowed Amount.		
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		

Vision Services For Members Through Age 18 Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam	\$0 Copayment	Not covered
Limited to one exam per Benefit Period		
Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Not covered
Bifocal	\$0 Copayment	Not covered
Trifocal	\$0 Copayment	Not covered
Progressive	\$0 Copayment	Not covered
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.		
Frames	\$0 Copayment	Not covered
Limited to one set of frames from the Anthem Formulary per Benefit Period.		
Contact Lenses		
Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.		

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Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Not covered
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Not covered
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		
	Benefits are based on the setting in which Covered Services are received.	Not covered

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further information.)

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call	Not covered

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	the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	
	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, [Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
• Precertification required	Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits or Office Visits depending where the service is performed.	
	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
Covered Transplant Procedure during the Transplant Benefit Period	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
Transportation and Lodging	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
• Transportation and Lodging Limit	Covered, as approved by us, up to [\$10,000] per transplant	Not covered
Unrelated donor searches from an authorized,	[Standard: No Copayment	Not covered

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licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure			/ Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	
• Donor Search Limit		Covered, as approved by us, up to [\$30,000] per transplant.	Not covered	
Live Donor Health Services		[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered	
• Donor Health Service Limit		Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Not covered	

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Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits

Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.

[Option: Prescription Drug Deductible (waived for Tier 1)]

Per Member

[\$250, 750]

Per Family

[\$500, 1,500]

[2014 Option: Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.]

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[Option: Prescription Drug Out of Pocket Limit]

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Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits
Per Member
\$6,350
Per Family
\$12,700

[2014 Option: Note: The Prescription Drug Out-of-Pocket Limit is separate and does not apply toward any other Out-of-Pocket Limit for Covered Services in this Plan. It includes all Deductibles, Coinsurance, and Copayments you pay for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy during a Benefit Period. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]

[2014 Option if Separate Rx OOP: Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy for the rest of the Benefit Period.]]

Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

Retail Pharmacy	30 days
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Home Delivery (Mail Order) Pharmacy	90 days
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Specialty Pharmacy	30 days*
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*See additional information in the "Specialty Drug Copayments / Coinsurance" section below.

In-Network
Out-of-Network
Retail Pharmacy Copayments / Coinsurance:

Tier 1 Prescription Drugs	[\$15 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 2 Prescription Drugs	[\$35, 50 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 3 Prescription Drugs	[\$70, 90 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 4 Prescription Drugs	[10%, 30% Coinsurance] [to a maximum of \$500] per Prescription Drug [after Deductible]	Not covered

Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$38 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 2 Prescription Drugs	[\$88, 125 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 3 Prescription Drugs	[\$175, 225 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 4 Prescription Drugs	[10%, 30% Coinsurance] [to a maximum of \$500] per Prescription Drug [after Deductible]	Not covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.		
[Optional: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will be have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.] [Standard: Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.] [HSA plans Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]		

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**Orally Administered Cancer
Chemotherapy**

[Use with all regular plans - No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.]

[Use with HSA coinsurance plans - Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.]

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.

How Your Plan Works

Introduction

Your Plan is a HMO plan. To get benefits for Covered Services, you must use In-Network Providers, unless we have approved an Authorized Service or if your care involves an Emergency or Urgent Care situation.

In-Network Provider Services

When you get care from an In-Network Provider or as part of an Authorized Service, benefits are available for Covered Services. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

Primary Care Physicians / Providers (PCP)

PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, and geriatricians. Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

If, when you first enroll (sign up) for coverage under this Plan, you are under the care of an Out-of-Network Provider, you should tell us right away. To keep getting care under this Plan from any Out-of-Network Provider, we must approve an Authorized Service with that Provider or the services will be denied.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any In-Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call us at the telephone number listed on the back of your Identification Card.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Off exchange only: Guest Memberships

When you or any of your covered dependents will be staying temporarily outside of the Service Area for more than 90 days, you can request a guest membership to a Blue Cross and Blue Shield affiliated health maintenance organization in that area. An example of when this service may be utilized is when a Dependent student attends a school outside of the service area. Call Customer Services at the number on the back of your ID card to make sure that the area in which you or your Dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated health maintenance organization plans. If the area is within the network, you will need to complete a guest membership application and you will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield health maintenance organization affiliate where you or your covered Dependents will be staying. A Customer Services representative will explain any limitations or restrictions to this benefit. If you are staying in an area that is not within the Guest Membership Network, this service will not be available.

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How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

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Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

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If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Service Area

The Service Area for this Plan is the State of Indiana.

[PC2 option:

Enhanced Personal Health Care Patient-Centered Primary Care Program

Certain Primary Care Providers are part of our **Enhanced Personal Health Care Patient-Centered Primary Care** Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in our Service Area. If you are receiving care from an In-Network Provider whose contractual relationship with us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated In-Network Provider for a set period.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

Off-exchange only: Crediting Prior Plan Coverage

If You were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then You will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If Your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and You were covered by the other product immediately before enrolling in this product with no break in coverage, then You may get credit for any accrued Deductible and Out-of-Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If Your Group offers more than one of our products, and You change from one product to another with no break in coverage, You will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If Your Group offers coverage through other products or carriers in addition to ours, and You change products or carriers to enroll in this product with no break in coverage, You will get credit for any accrued Deductible, Out-of-Pocket, and any maximums under this Plan.

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This Section Does Not Apply To You If:

- Your group moves to this Plan at the beginning of a Benefit Period;
- You ~~Cc~~change from one of our individual policies to a group plan;
- You ~~Cc~~change employers; or
- You ~~Aa~~are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need Emergency or urgent care services as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details. Please note that you only have coverage for Emergency and urgent care health care services when traveling outside the United States.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.

- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

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Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

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If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by an Out-of-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for an Out-of-Network Provider unless: - You get authorization to use an Out-of-Network Provider before the service is given; or - For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

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We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

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Request Categories

- Emergent Urgent – A** request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

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- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review**- A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an inpatient admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

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Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective Emergent/Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non- Emergent/Urgent	2 business days from the receipt of the request
Continued Stay Review Emergent/Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent/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
Continued Stay Review Non-Emergent/Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	
Prospective Emergent/Urgent	72 hours from the receipt of request
Prospective Non- Emergent/Urgent	15 calendar days from the receipt of the request
Continued Stay Review Emergent/Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent/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
Continued Stay Review Non-Emergent/Urgent	15 calendar days from the receipt of the request

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If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a ~~covered benefit~~Covered Service under your Plan;
4. The service cannot be subject to an exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary. These programs are given at no extra cost to you.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your ~~chosen~~authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop

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providing extended benefits or approving alternate care. In such case, we will notify you or your
| **authorized** representative in writing.

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What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

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Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

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Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recent Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;

- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

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Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

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Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

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Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recent Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18..

Prosthodontic Services

Tissue Conditioning

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an

Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

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Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;

- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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: (a)

place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means 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.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will not be covered unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

See "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** has been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

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Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered **benefits Services** for transportation and lodging include, but are not limited to:

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- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,

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- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.]

[Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.]

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape.

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Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- Inpatient Services in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- Outpatient Services including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often.
- Rehabilitation, therapy, and education.

- Inpatient Services in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation.

- Outpatient Services including treatment in an outpatient department of a Hospital and office visits.

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- **Day Treatment Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.

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You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care" benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in "Urgent Care Services" later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children with no current symptoms or history of a health problem.

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

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Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

- c-a. Women's contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."
- d-b. Breastfeeding support, supplies, and counseling. [Standard Benefits for breast pumps are limited to [1-10 one] pump per [Standard pregnancy] [Benefit Period].]
- e-c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites, [\[http://www.healthcare.gov/center/regulations/prevention.html\]](http://www.healthcare.gov/center/regulations/prevention.html), [\[http://www.ahrq.gov\]](http://www.ahrq.gov), and <http://www.cdc.gov/vaccines/acip/index.html>.]

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" later in this Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:]

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services, **All Members/All Ages)**" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

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Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.

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- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “[Prescription Drugs Administered by a Medical Provider](#)” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

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Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

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Vision Services For Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In Network.

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating.

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Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- h. Trifocal (FT 25-28)
- i. Progressive

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Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

iv. Elective Contact Lenses – Contacts chosen for comfort or appearance;

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v. Non-Elective Contact Lenses – Only for the following medical conditions:

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iv. Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.

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v. High Ametropia exceeding -12D or +9D in spherical equivalent.

vi. Anisometropia of 3D or more.

vii. When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

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Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

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Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- [Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. Smoking cessation products and

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over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.]

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

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We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

[Standard for all plans except HSA:

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.]

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1) Abortion Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. **This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a Doctor.**

2) Acts of War, Disasters, or Nuclear Accidents In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

3) Administrative Charges

a) Charges to complete claim forms,

b) Charges to get medical records or reports,

c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

4) Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

a. Acupuncture,

b. Holistic medicine,

c. Homeopathic medicine,

d. Hypnosis,

e. Aroma therapy,

f. Massage and massage therapy,

g. Reiki therapy,

h. Herbal, vitamin or dietary products or therapies,

i. Naturopathy,

j. Thermography,

k. Orthomolecular therapy,

l. Contact reflex analysis,

m. Bioenergetic synchronization technique (BEST),

n. Iridology-study of the iris,

o. Auditory integration therapy (AIT),

p. Colonic irrigation,

q. Magnetic innervation therapy,

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or, Electromagnetic therapy.

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

- 6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]

- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.

- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence. This Exclusion does not apply if you were the victim of a crime, including domestic violence.

- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

- Dental Treatment** Dental treatment, except as listed below.

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;
- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded.

This Exclusion does not apply to services that we must cover by law.

15) Dental Services

a) Dental care for Members age 19 or older.

b) Dental services not listed as covered in this Booklet.

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c) Oral hygiene instructions.	Formatted	... [1]
d) Case presentations.	Formatted	... [2]
e) Athletic mouth guards, enamel microabrasion and odontoplasty.	Formatted	... [3]
f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.	Formatted	... [4]
g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.	Formatted	... [5]
h) Pulp vitality tests.	Formatted	... [6]
i) Adjunctive diagnostic tests.	Formatted	... [7]
j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.	Formatted	... [8]
k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.	Formatted	... [9]
l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).	Formatted	... [10]
m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.	Formatted	... [11]
n) Incomplete root canals.	Formatted	... [12]
o) Bacteriologic tests for determination of periodontal disease or pathologic agents.	Formatted	... [13]
p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.	Formatted	... [14]
q) Provisional splinting, temporary procedures or interim stabilization.	Formatted	... [15]
r) Services of anesthesiologists, unless required by law.	Formatted	... [16]
s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.	Formatted	... [17]
t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.	Formatted	... [18]
u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.	Formatted	... [19]
v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.	Formatted	... [20]
w) Canal prep & fitting of preformed dowel & post.	Formatted	... [21]
x) Temporary, provisional or interim crown.	Formatted	... [22]
y) Occlusal procedures.	Formatted	... [23]
z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.	Formatted	... [24]
aa) Pin retention is not covered when billed separately from restoration procedure.	Formatted	... [25]
bb) Services for the replacement of an existing partial denture with a bridge.	Formatted	... [26]
cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).	Formatted	... [27]

dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

ee) Separate services billed when they are an inherent component of another covered service.

ff) Cone beam images.

gg) Anatomical crown exposure.

hh) Temporary anchorage devices.

ii) Sinus augmentation.

jj) Repair or replacement of lost/broken appliances.

- 16) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

- 17) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the process and criteria we use to determine if a Service is Experimental or Investigational are outlined below.

- 18) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

- 19) **Eye Exercises** Orthoptics and vision therapy.

- 20) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

- 21) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

- 22) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

ea) Cleaning and soaking the feet.

eb) Applying skin creams to care for skin tone.

ec) Other services that are given when there is not an illness, injury or symptom involving the foot.

- 23) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.

- 24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

- 25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

- 26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

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- 27) Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 28) Home Care**
 - a)** Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b)** Food, housing, homemaker services and home delivered meals.
- 29) Infertility Treatment** Testing or treatment related to infertility.
- 30) Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 31) Medical Equipment and Supplies**
 - a)** Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b)** Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c)** Non-Medically Necessary enhancements to standard equipment and devices.
- 32) Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- 33) Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 34) Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 35) Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 36) Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Urgent Care, or Authorized Services.
- 37) Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 38) Personal Care and Convenience**
 - a)** Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b)** First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c)** Home workout or therapy equipment, including treadmills and home gyms,
 - d)** Pools, whirlpools, spas, or hydrotherapy equipment.
 - e)** Hypo-allergenic pillows, mattresses, or waterbeds,
 - f)** Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

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•39) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.

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•40) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

• **Providers** Services you get from a non-covered Provider, as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

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• **Residential Treatment Centers** Unless we must cover them by law.

•41) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.

•42) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

•43) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.

•44) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

•45) **[Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]

•46) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

•47) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

•48) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

•49) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

•50) **Vision Services**

ea) Vision services for Members age 19 or older, unless listed as covered in this Booklet.

eb) Safety glasses and accompanying frames.

ec) For two pairs of glasses in lieu of bifocals.

ed) Plano lenses (lenses that have no refractive power)

ee) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.

ef) Vision services not listed as covered in this Booklet.

eg) Cosmetic lenses or options.

eh) Blended lenses.

ei) Oversize lenses.

ej) Sunglasses and accompanying frames.

ek) For services or supplies combined with any other offer, coupon or in-store advertisement.

el) For Members through age 18, no benefits are available for frames not on the Anthem formulary.

em) Certain frames in which the manufacturer imposes a no discount policy.

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- 51) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover **Bariatric Surgery per mandate option** This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

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- 52) **Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures].

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What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

- 1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

[Optional:

- 2. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at www.janthem.com.

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If you or your Physician believe you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE. We will cover your current Prescription Drug only if We agree that it is Medically Necessary and appropriate over its clinically equivalent alternative.]

- 3. **Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.

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[Religious opt out to exclude Contraceptive Drugs:

- 4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]

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- 5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

- 6. **Delivery Charges** Charges for delivery of Prescription Drugs.

- 7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.

- | **8. Drugs Not on the Anthem Prescription Drug List (a formulary).** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Physician believe you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
- | **9. Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- | **10. Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
- | **11. Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- | **12. Fluoride Treatments** Topical and oral fluoride treatments.
- | **13. Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
- | **14. Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
- | **15. Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
- | **16. Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
- | **17. Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- | **18. Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
- | **19. Non-approved Drugs** Drugs not approved by the FDA.
- | **20. Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- | **21. Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- | **22. Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

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This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.

- 23. Sex Change Drugs** Drugs for sex change surgery.
- 24. Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
- 25. Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- 26. Weight Loss Drugs** Any Drug mainly used for weight loss.

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EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan. Details on the process and criteria your Plan uses to decide if a service is Experimental or Investigational are outlined below.

If you disagree with our denial of a service as Experimental or Investigational, you have the right to file a Grievance with us. Please refer the **Grievance and External Review Procedures** section of this Booklet for more information.

Process to Determine an Experimental or Investigational Service

Our process to decide whether a service is Experimental or Investigational includes medical and technical research of the service, committee review and decision, and final approval by our Chief Medical Officer.

First, our medical policy staff reviews a service based on the criteria listed in the provision below. Information on the service is gathered and combined by our Medical policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of our formal policy.

Next, the draft of the policy and literature on the service is distributed to the medical policy committee for review and discussion. The committee, which meets four times a year, is made up of a panel of Plan Physicians, most of which are actively practicing In-Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory organizations. The committee may also ask for input from one or more Physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the service, the committee recommends a final policy. The policy is forwarded to the medical policy committee chairman and Chief Medical Officer for approval.

Our policy on a service is reviewed as appropriate, every three years or less, by our medical policy staff and medical policy committee, with approval of our Chief Medical Officer and medical policy committee chairman.

We also maintain a process for deciding when existing policy on a service calls for added review and change and alerts our medical policy committee of the need to change the existing policy or make a new policy. This may come about as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change our position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by us to make policy change between regularly scheduled meetings of the medical policy committee.

Criteria to Determine an Experimental or Investigational Service

The criteria we or our designee use when making the determination of whether a Service is Experimental or Investigational when it is rendered for the evaluation or treatment of a disease, injury, illness or

condition is outlined below. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

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Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Out-of-Area Services" "Inter-Plan Programs" later in this section for additional information.

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The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

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You will be required to pay a portion of the Maximum Allowed Amount to the extent you have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under this product are not covered except for Emergency Care, or when allowed as an Authorized Service by us. When you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency Care, or unless the services are approved by us as an Authorized Service.

For Covered Services You receive from an Out-of-Network Provider for Emergency Care or for services approved as an Authorized Service, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

If you receive Covered Services in an In-Network Provider facility from an Out-of-Network Provider, such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with the In-Network Hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Care or Urgent Care services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

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Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

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Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a

Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

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Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("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.

Typically, when accessing care outside Anthem's Service Area and the Service Area of Anthem's corporate parent, 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 non-participating healthcare Providers. Anthem's payment practices in both instances are described below.

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care and urgent care obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your Primary Care Physician ("PCP").

BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area 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.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount, as stated in your Booklet.

Emergency Care Services: If you experience a Medical Emergency while traveling outside the Anthem Service Area, go to the nearest Emergency or Urgent Care Facility.

Whenever you access covered healthcare services outside Anthem's and, if applicable, Anthem's corporate parent's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special

arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. A Out-of-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 [(carve-out) Medicare,] 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

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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

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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.

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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

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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 generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment

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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.

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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.

"Recovery" means is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

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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:

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- 1. The amount we paid on your behalf is not repaid or otherwise recovered by us; or
- 2. you fail to cooperate.

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- 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.

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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.

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Your Member Rights and Responsibilities as an Anthem Blue Cross and Blue Shield Member

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.

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▪ Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.

▪ Follow the care plan that you have agreed on with your Doctors or health care Providers.

▪ Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.

▪ Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

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We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

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If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card. 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.

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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.

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• Work with your doctors in making choices about your health care.

• Be treated with respect, dignity, and the right to privacy.

• Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.

• Get information about our company and services, and our network of doctors and other health care Providers.

• Get more information about your rights and responsibilities and give us your thoughts and ideas about them.

• Give us your thoughts and ideas about any of the rules of your Plan and in the way your Plan works.

• Make a complaint or file an appeal about:

o Your Plan

o Any care you get

o Any Covered Service or benefit ruling that your Plan makes.

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• 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.

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• 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.

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• Treat all doctors, health care professionals and staff with courtesy and respect.

• Keep all scheduled appointments with your health care Providers and call their office if you have a delay or need to cancel.

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all Plan rules and policies.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read the rest of this Booklet.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

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Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-317800-287368-59683238] if you wish to file your Grievance by fax.

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For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

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For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3 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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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.

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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 utilization review determination; 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 Booklet; 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
- ♦ The service is not specifically excluded in this Booklet.

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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 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.]

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Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

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Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- [Domestic partner coverage: [This only applies to Groups who have this option:]] The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who [Standard when affidavit used] has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for [12 months] or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

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For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

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- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

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All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- 1. For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

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We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Plan unless required by the laws of this state.

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Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- Subscriber and one child;
- Subscriber and children;
- Subscriber and family.

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When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll [during an Open Enrollment period or] during a Special Enrollment period, as described below.

[Open Enrollment

Open Enrollment refers to a period of time, usually [60 days], during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted

otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.
- Lost eligibility under a prior health plan for reasons other than non-payment of premium (or contribution to premium) or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

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Important Notes about Special Enrollment:

1. Members who enroll during Special Enrollment are **not** considered Late Enrollees.
2. Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
3. Evidence of prior creditable coverage is required and must be furnished by you or your prior carrier.

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Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

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You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

1. The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
2. The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

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The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they may apply for coverage at any time during the year as a Late Enrollee. However, you will not be eligible to enroll until the next Open Enrollment Period.

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Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- 2. The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- 3. Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

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Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the

applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

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Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- | •• When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | •• If you choose to terminate your coverage. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | •• If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | •• If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | •• If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | • If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents. Formatted: Indent: Left: 0", Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- | • If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse. Formatted: Indent: Left: 0", Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- | •• If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another Group health plan.

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Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

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Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
<u>For Dependents:</u>	
A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

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If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

If we terminate the Group Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, we will continue your coverage for Inpatient Covered Services. Coverage will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after the Group Contract terminated;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by us;
- The Premium is not paid within the grace period shown in the Group Contract.

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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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

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The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

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Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

- 1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
- 2. 24 months from the date your leave began.

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Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

- 1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

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- ♦2. 14 days of completing your military service for leaves of 31 to 180 days; or
- ♦3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

- ♦1. Two years; or
- ♦2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

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General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Corporate Structure

The Plan is an Indiana domiciled insurance corporation owned by its stockholders and directed by a board of directors, who provide general leadership to the Plan. It is managed by a team of officers who receive direction from the board of directors and in turn direct the operations of the Plan. The Plan consists of a number of operational divisions including, but not limited to: Operations, Medical Management, Network Development, Marketing, Claims Administration, Risk Management, Legal and Member Services.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

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Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled.

You should enroll in Medicare Part B as soon as possible to avoid potential liability.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing

eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

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Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives

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such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.) We may offer health or fitness related program options for purchase by your Group. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed and could be discontinued at any time. If your Group has selected one of these options, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors when administered according to state or federal law. However, if it is unreasonably difficult due to a medical condition for you to achieve the standards for a reward under such a program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive gift cards and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

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Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

- ~~6-1.~~ Is licensed as required;
- ~~7-2.~~ Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
- ~~8-3.~~ Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
- ~~9-4.~~ Does not have Inpatient accommodations; and
- ~~10-5.~~ Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "Benefits After Termination."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Medical technology or a new application of existing medical technology, including medical procedures, Drugs, and devices for treating a medical condition, illness, or diagnosis that:

- is not generally accepted by informed health care professionals in the United States as effective; or

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- has not been proven by scientific testing or evidence to be effective;
- in treating the medical condition, illness, or diagnosis for which its use is proposed.
- For how this is determined, see the "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "~~Eligibility and Enrollment – Adding Members~~~~Eligibility and Enrollment – Adding Members~~" section for further details.

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Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

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[Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.]

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

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The most you pay during a Benefit Period for Covered Services before your Plan begins benefits. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Schedule of Benefits" for details.

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Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Predetermination

Please see the section "Getting Approval for Benefits " for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
- Insulin, diabetic supplies, and syringes.

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Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

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A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Covered Providers are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

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Recovery

Please see the “Subrogation and Reimbursement” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by state regulatory agencies.

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Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

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Certificate of Coverage

(Referred to as "Booklet" in the following pages)

**Anthem Bronze Blue Preferred [on exchange only: X] POS 6000/30%/6600
PlusAnthem Bronze DirectAccess Plus**

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Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

[on-exchange only:] If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.]

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Anthem Insurance Companies, Inc.
[120 Monument Circle]
[Indianapolis, Indiana 46204]

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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, [\[www.anthem.com\]](http://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, [\[www.anthem.com\]](http://www.anthem.com)

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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~~If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends.~~

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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/doi

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.


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President

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] off-exchange only: Plan Year
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

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Deductible	In-Network	Out-of-Network
Per Member	\$56,000	\$1012,000
Per Family - All other Members combined	\$1012,000	\$2024,000
The In-Network and Out-of-Network Deductibles are separate and cannot be combined.		
When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.		
Copayments and Coinsurance are separate from and do not apply to the Deductible.		

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Coinsurance	In-Network	Out-of-Network
Plan Pays	70%	50%
Member Pays	30%	50%
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.		
Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	\$6,3596,600	\$12,70013,200
Per Family – All other Members combined	\$12,70013,200	\$25,40026,400
The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.		
The Out-of-Pocket Limit does not include amounts you pay for following benefits:		
Out-of-Network Human Organ and Tissue Transplant services.		
Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above.		
The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

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Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network	Formatted Table
Allergy Services	Benefits are based on the setting in which Covered Services are received.		
Ambulance Services (Air and Water)	30% Coinsurance after Deductible		
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.			
			Formatted Table
Ambulance Services (Ground)	30% Coinsurance after Deductible		
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.			
			Formatted Table
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.		
Behavioral Health Services	See "Mental Health and Substance Abuse Services."		
Cardiac Rehabilitation	See "Therapy Services."		
Chemotherapy	See "Therapy Services."		
Clinical Trials	Benefits are based on the setting in which Covered Services are received.		

Benefits	In-Network	Out-of-Network	Formatted Table
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.		
Dental Services Accidental Injury Benefit Maximum	\$3,000 per Accidental Injury In- and Out-of-Network combined		
Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that we are required to cover by law.			
			Formatted Table
Dental Services For Members Through Age 18			Formatted: Highlight
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.			Comment [tdw1]: Embedding pediatric dental this year
Diagnostic and Preventive Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible	Formatted: Highlight
Basic Restorative Services	40% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight
Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight
Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight
Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight
Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight
Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight
Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight
Dentally Necessary Orthodontic Care Waiting Period			Formatted: Highlight
12 Months			
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under “Preventive Care.”		
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.		

Benefits	In-Network	Out-of-Network
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Wigs Needed After Cancer Treatment Benefit Maximum The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.	One wig per Benefit Period In- and Out-of-Network combined	
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	\$250 Copayment per visit plus 30% Coinsurance after Deductible	
	Copayment waived if admitted	
Emergency Room Doctor Charge	30% Coinsurance after Deductible	
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	
Home Care		
Home Care Visits	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Dialysis	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Infusion Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Benefits	In-Network	Out-of-Network
Specialty Prescription Drugs	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Home Care Services / Supplies	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period In- and Out-of-Network combined	
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period In- and Out-of-Network combined	
	164 visits per Lifetime In- and Out-of-Network combined	
Home Infusion Therapy	See “Home Care.”	
Hospice Care		
- Home Care - Respite Hospital Stays	0% Coinsurance after Deductible	50% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Benefits	In-Network	Out-of-Network	Formatted Table
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.			
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.			
Doctor Services for:			Formatted Table
General Medical Care / Evaluation and Management (E&M)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Maternity and Reproductive Health Services			
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.			
Inpatient Services (Delivery)	See "Inpatient Services"		
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.			
			Formatted Table
Mental Health and Substance Abuse Services			
Inpatient Facility Services	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Residential Treatment Center Services	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible	Comment [tdw2]: Added for MHP compliance
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Inpatient Doctor Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Outpatient Facility Services	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network	Formatted Table
Outpatient Doctor Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Partial Hospitalization Program / Intensive Outpatient Services	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Office Visits	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.			
			Formatted Table
Occupational Therapy	See "Therapy Services."		
Office Visits			
Primary Care Physician / Provider (PCP)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Specialty Care Physician / Provider (SCP)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Retail Health Clinic Visit	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Online Visit	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Nutritional Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight

Benefits	In-Network	Out-of-Network
• Nutritional Counseling for Eating Disorders	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Testing	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (other than allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Lab (non-preventive)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic X-ray (non-preventive)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Tests (non-preventive; including hearing and EKG)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Therapy Services:		
- Chiropractic Care & Spinal Manipulation	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
- Physical, Speech, & Occupational Therapy	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
- Dialysis / Hemodialysis	30% Coinsurance after Deductible	50% Coinsurance after Deductible
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	30% Coinsurance after Deductible	50% Coinsurance after Deductible
- Cardiac Rehabilitation & Pulmonary Therapy	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		

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Benefits	In-Network	Out-of-Network
Prescription Drugs Administered in the Office (includes allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.		
Orthotics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	
Outpatient Facility Services		
Facility Surgery Charge	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Doctor Surgery Charges	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Lab	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic X-ray	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Benefits	In-Network	Out-of-Network
- Therapy: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Dialysis / Hemodialysis - Cardiac Rehabilitation & Pulmonary Therapy See "Therapy Services" for details on Benefit Maximums. - Prescription Drugs Administered in an Outpatient Facility	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible
Physical Therapy	See "Therapy Services."	
Preventive Care	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Pulmonary Therapy	See "Therapy Services."	
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See "Therapy Services."	

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Benefits	In-Network	Out-of-Network
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	See "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received.	
[optional offer mandate – add when selected –Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime In- and Out-of-Network combined]	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
Physical Therapy	20 visits per Benefit Period	
Occupational Therapy	20 visits per Benefit Period	
Speech Therapy	20 visits per Benefit Period	
Manipulation Therapy	20 visits per Benefit Period	
Cardiac Rehabilitation	36 visits per Benefit Period	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	

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Benefits	In-Network	Out-of-Network
Urgent Care Services (Office Visits)		
• Urgent Care Office Visit Charge	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Testing	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (other than allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (includes allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Vision Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
• Routine Eye Exam	\$0 Copayment	Covered up to \$30
Limited to one exam per Benefit Period		
• Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Covered up to \$25

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Benefits	In-Network	Out-of-Network
Bifocal	\$0 Copayment	Covered up to \$40
Trifocal	\$0 Copayment	Covered up to \$55
Progressive	\$0 Copayment	Covered up to \$40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.		
Frames Limited to one set of frames from the Anthem Formulary per Benefit Period.	\$0 Copayment	Covered up to \$45
Contact Lenses Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		
Benefits are based on the setting in which Covered Services are received.		

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Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further details.)

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services, related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of- Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
• Precertification required	During the Transplant Benefit Period, no Copayment / Deductible / Coinsurance.	During the Transplant Benefit Period, You will pay 50% Coinsurance after Deductible.

	Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers No Copayment / Deductible / Coinsurance	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers 50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.

• Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant In- and Out-of-Network combined	Limit.
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible
		These charges will NOT apply to your Out-of-Pocket Limit.
• Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant In- and Out-of-Network combined	
Live Donor Health Services	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible
		These charges will NOT apply to your Out-of-Pocket Limit.
• Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Prescription Drug Deductible (waived for Tier 1)		
Per Member	\$250 In- and Out-of-Network combined	
Per Family	\$500 In- and Out-of-Network combined	
Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.		
Prescription Drug Out of Pocket Limit		
Per Member	\$6,350 In- and Out-of-Network combined	
Per Family	\$12,700 In- and Out-of-Network combined	
[2014 Option: Note: The Prescription Drug Out of Pocket Limit is separate and does not apply toward any other Out of Pocket Limit for Covered Services in this Plan. It includes all Deductibles, Coinsurance, and Copayments you pay for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy during a Benefit Period. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]		
[2014 Option if Separate Rx OOP: Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy for the rest of the Benefit Period.]		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy (In-Network and Out-of-Network)	30 days*	
*See additional information in the “Specialty Drug Copayments / Coinsurance” section below.		
Retail Pharmacy Copayments / Coinsurance:		

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Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 1 Prescription Drugs	\$15 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 2 Prescription Drugs	\$35 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 3 Prescription Drugs	\$70 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 4 Prescription Drugs	\$30% Coinsurance to a maximum of \$500 per Prescription Drug	50% Coinsurance per Prescription Drug
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$38 Copayment per Prescription Drug	Not Covered
Tier 2 Prescription Drugs	\$88 Copayment per Prescription Drug	Not Covered
Tier 3 Prescription Drugs	\$175 Copayment per Prescription Drug	Not Covered
Tier 4 Prescription Drugs	\$30% Coinsurance to a maximum of \$500 per Prescription Drug	Not Covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy. [Optional: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.]		

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.		
Orally Administered Cancer Chemotherapy	No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In--Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.	
	No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-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.	

How Your Plan Works

Introduction

Your Plan is a Point of Service (POS) plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

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Service Area

The Service Area for this Plan is the State of Indiana.

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Enhanced Personal Health Care Patient-Centered Primary Care Program

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Certain Primary Care Providers are part of our Enhanced Personal Health Care Patient-Centered Primary Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in our Service Area. If you are receiving care from an In-Network Provider whose contractual relationship with us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated In-Network Provider for a set period.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

Off exchange only: Crediting Prior Plan Coverage

If You were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then You will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If Your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and You were covered by the other product immediately before enrolling in this product with no break in coverage, then You may get credit for any accrued Deductible and Out-of-Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If Your Group offers more than one of our products, and You change from one product to another with no break in coverage, You will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If Your Group offers coverage through other products or carriers in addition to ours, and You change products or carriers to enroll in this product with no break in coverage, You will get credit for any accrued Deductible, Out-of-Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your group moves to this Plan at the beginning of a Benefit Period;
- **You Change** from one of our individual policies to a group plan;
- **You Change** employers; or
- **You are** a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need Emergency or urgent care services, as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

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To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details. Please note that you only have coverage for Emergency and urgent care health care services when traveling outside the United States.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bCBS.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

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If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by a BlueCard/Out-of-Network/Non-Participating Provider
Provider	- Member must get Precertification. - If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. - For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

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Request Categories

- Emergent Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

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- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review**- A request for Precertification or Predetermination that is conducted during the course of **outpatient treatment or during an inpatient** admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

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Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective EmergentUrgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non- EmergentUrgent	2 business days from the receipt of the request
Continued Stay Review UrgentEmergent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review UrgentEmergent 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
Continued Stay Review Non- UrgentEmergent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	
Prospective UrgentEmergent	72 hours from the receipt of request
Prospective Non- UrgentEmergent	15 calendar days from the receipt of the request
Continued Stay Review UrgentEmergent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review UrgentEmergent 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
Continued Stay Review Non- UrgentEmergent	15 calendar days from the receipt of the request

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If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a ~~covered benefit~~Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

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Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary. These programs are given at no extra cost to you.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your ~~chosen~~authorized representative, treating Doctor(s), and other Providers.

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In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop

providing extended benefits or approving alternate care. In such case, we will notify you or your
| **authorized** representative in writing.

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What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;**
- b) A morgue or funeral home.**

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Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

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Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

Comment [tdw3]: Embedded pediatric dental new for this year

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap
- Osseous surgery
- Bone replacement graft
- Pedicle soft tissue graft
- Free soft tissue graft
- Subepithelial connective tissue graft

- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recent Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18..

Prosthodontic Services

Tissue Conditioning

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed

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Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an

Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

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Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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: (a) place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means 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.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor does not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis.

Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

See "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** has been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you

coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered **benefits Services** for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,

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- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.

- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.

6. Immunoreactive trypsin (IRT).
7. DNA testing.

[Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.]

[Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.]

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape.

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Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often.
 - Rehabilitation, therapy, and education.
- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation.

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- **Outpatient Services** including treatment in an outpatient department of a Hospital and office visits.
- **Day Treatment Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care" benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in "Urgent Care Services" later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children with no current symptoms or history of a health problem.

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

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Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women's contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."]
 - b. Breastfeeding support, supplies, and counseling. [Standard Benefits for breast pumps are limited to [1-10 one] pump per [Standard pregnancy] [Benefit Period].]
 - c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites, [\[http://www.healthcare.gov/center/regulations/prevention.html\]](http://www.healthcare.gov/center/regulations/prevention.html), [\[http://www.ahrq.gov\]](http://www.ahrq.gov), and [\[http://www.cdc.gov/vaccines/acip/index.html\]](http://www.cdc.gov/vaccines/acip/index.html).

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" later in this Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:]

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services **All Members/All Ages**" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

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Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "[Prescription Drugs Administered by a Medical Provider](#)" for more details.

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- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “[Prescription Drugs Administered by a Medical Provider](#)” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

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Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services For Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In Network.

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating.

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Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "~~Prescription Drugs Administered by a Medical Provider~~ Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

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Prescription Drug Benefits

As described in the "~~Prescription Drugs Administered by a Medical Provider~~ Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

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Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "~~Prescription Drugs Administered by a Medical Provider~~ Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- [Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. Smoking cessation products and

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over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.]

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;

- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs. This tier contains higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1) Abortion Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. **This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details. This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a Doctor.**

2) Acts of War, Disasters, or Nuclear Accidents In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

3) Administrative Charges

- a) Charges to complete claim forms,
- b) Charges to get medical records or reports,
- c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

4) Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

- a. Acupuncture,
- b. Holistic medicine,
- c. Homeopathic medicine,
- d. Hypnosis,
- e. Aroma therapy,
- f. Massage and massage therapy,
- g. Reiki therapy,
- h. Herbal, vitamin or dietary products or therapies,
- i. Naturopathy,
- j. Thermography,
- k. Orthomolecular therapy,
- l. Contact reflex analysis,
- m. Bioenergetic synchronization technique (BEST),
- n. Iridology-study of the iris,
- o. Auditory integration therapy (AIT),
- p. Colonic irrigation,
- q. Magnetic innervation therapy,
- r. Electromagnetic therapy.

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5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

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5) 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

6) 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

7) 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

8) 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]

9) 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.

10) 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

11) 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence. This Exclusion does not apply if you were the victim of a crime, including domestic violence.

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12) 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

15) Dental Services

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a) Dental care for Members age 19 or older.

b) Dental services not listed as covered in this Booklet.

c) Oral hygiene instructions.

d) Case presentations.

e) Athletic mouth guards, enamel microabrasion and odontoplasty.

f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.

g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.

h) Pulp vitality tests.

i) Adjunctive diagnostic tests.

- i) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- n) Incomplete root canals.
- o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
- p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- q) Provisional splinting, temporary procedures or interim stabilization.
- r) Services of anesthesiologists, unless required by law.
- s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- w) Canal prep & fitting of preformed dowel & post.
- x) Temporary, provisional or interim crown.
- y) Occlusal procedures.
- z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- aa) Pin retention is not covered when billed separately from restoration procedure.
- bb) Services for the replacement of an existing partial denture with a bridge.
- cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- ee) Separate services billed when they are an inherent component of another covered service.
- ff) Cone beam images.
- gg) Anatomical crown exposure.
- hh) Temporary anchorage devices.
- ii) Sinus augmentation.
- jj) Repair or replacement of lost/broken appliances.

13) **Dental Treatment** Dental treatment, except as listed below:

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;
- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded.

This Exclusion does not apply to services that we must cover by law.

~~14)~~**16) Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

~~15)~~**17) Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the process and criteria we use to determine if a Service is Experimental or Investigational are outlined below.

~~16)~~**18) Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

~~17)~~**19) Eye Exercises** Orthoptics and vision therapy.

~~18)~~**20) Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

~~19)~~**21) Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

~~20)~~**22) Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

- a) Cleaning and soaking the feet.
- b) Applying skin creams to care for skin tone.
- c) Other services that are given when there is not an illness, injury or symptom involving the foot.

~~21)~~**23) Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.

~~22)~~**24) Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

~~23)~~**25) Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

~~24)~~**26) Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

- | ~~25)~~27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- | ~~26)~~28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- | ~~27)~~29) **Infertility Treatment** Testing or treatment related to infertility.
- | ~~28)~~30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- | ~~29)~~31) **Medical Equipment and Supplies**
 - a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
- | ~~30)~~32) **Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- | ~~31)~~33) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- | ~~32)~~34) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- | ~~33)~~35) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- | ~~34)~~36) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- | ~~35)~~37) **Personal Care and Convenience**
 - a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c) Home workout or therapy equipment, including treadmills and home gyms,
 - d) Pools, whirlpools, spas, or hydrotherapy equipment.
 - e) Hypo-allergenic pillows, mattresses, or waterbeds,
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- | ~~36)~~38) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.

37) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

38) **Providers** Services you get from a non-covered Provider, as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

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39) **Residential Treatment Centers** Unless we must cover them by law.

40) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.

41) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

42) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.

43) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

44) **[Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]

45) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

46) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

47) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

48) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

49) **Vision Services**

- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
- b) Safety glasses and accompanying frames.
- c) For two pairs of glasses in lieu of bifocals.
- d) Plano lenses (lenses that have no refractive power)
- e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
- f) Vision services not listed as covered in this Booklet.
- g) Cosmetic lenses or options.
- h) Blended lenses.
- i) Oversize lenses.
- j) Sunglasses and accompanying frames.
- k) For services or supplies combined with any other offer, coupon or in-store advertisement.
- l) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
- m) Certain frames in which the manufacturer imposes a no discount policy.

50) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover **Bariatric Surgery per mandate option** This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

- 51) **Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery**
Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgeries that reduce stomach size), or gastric banding procedures].

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **[optional - Clinically-Equivalent Alternatives]** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over its clinically equivalent alternative.]

3. **Compound Drugs** **Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer** **Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.**

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[Religious group opt out to exclude Contraceptive drugs:

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com.] If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.

9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments.
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
15. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
16. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
18. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

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26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan. Details on the process and criteria your Plan uses to decide if a service is Experimental or Investigational are outlined below.

If you disagree with our denial of a service as Experimental or Investigational, you have the right to file a Grievance with us. Please refer the **Grievance and External Review Procedures** section of this Booklet for more information.

Process to Determine an Experimental or Investigational Service

Our process to decide whether a service is Experimental or Investigational includes medical and technical research of the service, committee review and decision, and final approval by our Chief Medical Officer.

First, our medical policy staff reviews a service based on the criteria listed in the provision below. Information on the service is gathered and combined by our Medical policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of our formal policy.

Next, the draft of the policy and literature on the service is distributed to the medical policy committee for review and discussion. The committee, which meets four times a year, is made up of a panel of Plan Physicians, most of which are actively practicing In-Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory organizations. The committee may also ask for input from one or more Physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the service, the committee recommends a final policy. The policy is forwarded to the medical policy committee chairman and Chief Medical Officer for approval.

Our policy on a service is reviewed as appropriate, every three years or less, by our medical policy staff and medical policy committee, with approval of our Chief Medical Officer and medical policy committee chairman.

We also maintain a process for deciding when existing policy on a service calls for added review and change and alerts our medical policy committee of the need to change the existing policy or make a new policy. This may come about as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change our position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by us to make policy change between regularly scheduled meetings of the medical policy committee.

Criteria to Determine an Experimental or Investigational Service

The criteria we or our designee use when making the determination of whether a Service is Experimental or Investigational when it is rendered for the evaluation or treatment of a disease, injury, illness or condition is outlined below. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "[Out-of-Area Services](#)" and "[Inter-Plan Programs](#)" later in this section for additional information.

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The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket

responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total out of pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*
- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of*

\$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.

- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of \$1500, or \$450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is \$500, you may receive a bill from the Out-of-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your In-Network Copayment of \$25, your total out of pocket expense would be \$325.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

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Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

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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.

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency and urgent care obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

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, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Anthem serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Booklet.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When covered healthcare services are provided outside of our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. A Out-of-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 *[(carve-out) Medicare]* 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 generally 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.

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.

"Recovery" means is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Member Your Rights and Responsibilities as an Anthem Blue Cross and Blue Shield Member

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.

- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.
- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card. As an Anthem Blue Cross and Blue Shield (Anthem) Member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights" and helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care Providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your Plan and in the way your Plan works.
- Make a complaint or file an appeal about:
 - Your Plan
 - Any care you get
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Participate in matters that deal with our policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any Primary Care Physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers and call their office if you have a delay or need to cancel.

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all Plan rules and policies.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read the rest of this Booklet.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

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Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-800-368-3238] if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3 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).

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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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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 Booklet.

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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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 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.

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[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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- **The Subscriber's spouse.** For information on spousal eligibility please contact the Group. The Subscriber's spouse as recognized under the laws of the state where the Subscriber lives.
- **[Domestic partner coverage option: This only applies to Groups who have this option:]** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who [Standard when affidavit used] has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for [12 months] or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

- **[Standard when affidavit used:]** To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]
- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

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- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Plan unless required by the laws of this state.

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Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- Subscriber and one child;
- Subscriber and children;
- Subscriber and family.

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When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during [an Open Enrollment period or during] a Special Enrollment period, as described below.

[Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.
- Lost eligibility under a prior health plan for reasons other than non-payment of premium (or contribution to premium) or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

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Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- Evidence of prior creditable coverage is required and must be furnished by you or your prior carrier.

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Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they may apply for coverage at any time during the year as a Late Enrollee. However, you will not be eligible to enroll until the next Open Enrollment Period.

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Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, or age.

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Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another Group health plan.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u>	
Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
<u>For Dependents:</u>	
A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

If we terminate the Group Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, we will continue your coverage for Inpatient Covered Services. Coverage will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after the Group Contract terminated;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by us;
- The Premium is not paid within the grace period shown in the Group Contract.

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or

3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Corporate Structure

The Plan is an Indiana domiciled insurance corporation owned by its stockholders and directed by a board of directors, who provide general leadership to the Plan. It is managed by a team of officers who receive direction from the board of directors and in turn direct the operations of the Plan. The Plan consists of a number of operational divisions including, but not limited to: Operations, Medical Management, Network Development, Marketing, Claims Administration, Risk Management, Legal and Member Services.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled.

You should enroll in Medicare Part B as soon as possible to avoid potential liability.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing

eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.]

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

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Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives

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such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.) We may offer health or fitness related program options for purchase by your Group. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed and could be discontinued at any time. If your Group has selected one of these options, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors when administered according to state or federal law. However, if it is unreasonably difficult due to a medical condition for you to achieve the standards for a reward under such a program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive gift cards and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

-Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "Benefits After Termination."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Medical technology or a new application of existing medical technology, including medical procedures, Drugs, and devices for treating a medical condition, illness, or diagnosis that:

- is not generally accepted by informed health care professionals in the United States as effective; or

- has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

For how this is determined, see the "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "~~Eligibility and Enrollment – Adding Members~~~~Eligibility and Enrollment – Adding Members~~" section for further details.

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Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

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Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

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The most you pay during a Benefit Period for Covered Services before your Plan begins benefits. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Schedule of Benefits" for details.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Predetermination

Please see the section "Getting Approval for Benefits " for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 1) Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
- 2) Insulin, diabetic supplies, and syringes.

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Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Covered Providers are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

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Recovery

Please see the “Subrogation and Reimbursement” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by state regulatory agencies.

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Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

STATEMENT OF VARIABILITY
Small Group HMO–On Exchange Product
For Certificate Form ABCBS-SG HMO-ON/OFF EXCH-v02

General Variable Information

Most numbers (excluding the form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Definitions may vary to the extent that such definition may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Website URL addresses (e.g. [www.anthem.com]) are bracketed throughout the certificate for removal if necessary or to update if the web addresses changes.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval.

Informational text in blue in the certificate of coverage are our internal filing notes describing bracketed options, brackets and the language that does not apply to a particular Certificate of Coverage. This informational text is for filing purposes only and is removed prior to printing the Certificate of Coverage.

Please note that the deductible, out of pocket and cost shares value ranges bracketed in the schedule will only be arranged to match our companies small group benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

Specific Variable Information

The following is an explanation of the variables used within this certificate form.

Section	Subsection(s)/ Provision(s)	Variable Use
Front Cover		Product Names is bracketed to allow for different names to appear depending on a group's benefit selection. The following note only appears in certificates for on exchange plans: If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596. Anthem Logo and Company address is bracketed to allow for future change.
Additional Federal Notices	Statement of ERISA Rights	The entire subsection is bracketed to allow for inclusion or removal depending if group is subject to ERISA.
Notices Required by State Law	Notice to Members	Phone number is bracketed to allow for future change.

Section	Subsection(s)/ Provision(s)	Variable Use
Introduction	High-Deductible Health Plan for Use with Health Savings Accounts	The entire subsection is bracketed to allow for inclusion or removal depending if group has an HSA product.
Introduction	Company president signature	Company president signature is bracketed to allow for future change.
Schedule of Benefits	Benefit Period	On exchange plans only have option for Calendar year. Off-exchange plans can offer both calendar year & Plan year.
Schedule of Benefits	Deductible	Deductible amount option ranges are as shown in schedule. Standardly we include both member & family deductibles. However, we also have “Non-Embedded” plan options available for our HSA plans. The paragraph applicable to those plans in brackets would be included.
Schedule of Benefits	Coinsurance	Coinsurance amount ranges are as shown in schedule.
Schedule of Benefits	Out of Pocket Limit	Standardly we include both member & family Out of Pocket. Standardly we include both member & family deductibles. However, we also have “Non-Embedded” plan options available for our HSA plans. The paragraph applicable to those plans in brackets would be included.
Schedule of Benefits	Ambulance Services (Land / Air)	Cost Share options ranges are as shown in the schedule.
Schedule of Benefits	Diagnostic Services	We include an optional sentence for Preferred Diagnostic Lab. If unique cost shares would apply then this sentence would be included. This option does not apply to HSA plans since it is waiving cost share.
Schedule of Benefits	Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies	Cost Share options ranges are as shown in the schedule.
Schedule of Benefits	Emergency Room Services	Cost Share options ranges are as shown in the schedule.
Schedule of Benefits	Home Care Services	Cost Share options ranges are as shown in the schedule.
Schedule of Benefits	Inpatient Services (Facility and professional services)	Cost Share options ranges are as shown in the schedule. There are optional sentences included in brackets for products that include hospital flat (\$) dollar copayments. Language is bracketed to either include or remove. If a product is selected that includes a flat (\$) dollar copayments, this language will be included.

Section	Subsection(s)/ Provision(s)	Variable Use
Schedule of Benefits	Maternity Services	Cost Share options ranges are as shown in the schedule. We also include optional notes depending if deductible is waived or if it applies.
Schedule of Benefits	Mental Health and Substance Abuse Services	Cost Share options ranges are as shown in the schedule. We also include optional notes depending if deductible is waived or if it applies.
Schedule of Benefits	Office Visits	Cost Share options ranges are as shown in the schedule.
Schedule of Benefits	Outpatient Facility Services	Cost Share options ranges are as shown in the schedule.
Schedule of Benefits	Surgery	The bariatric surgery benefit is bracketed to either be included or be removed in its entirety depending if a small groups opts to include this benefit per state mandate.
Schedule of Benefits	Urgent Care Services	Cost Share options ranges are as shown in the schedule. We also include optional notes depending if deductible is waived or if it applies.
Schedule of Benefits	Human Organ and Tissue transplant (HOTT) services	Cost Share options for standard plans and HSA plans are as shown in the schedule.
Schedule of Benefits	Prescription Drugs	The prescription drug deductible provision is bracketed for use with some of our plan offerings. The entire provision is included or removed depending on the benefit plan selected. It is also not used with HSA plans. The note applicable to this provision in brackets will only be included for 2014 plan year per guidance that drug deductibles do not have to apply toward overall plan deductible. Prescription drug Cost Share options are as shown in the schedule. Brand penalty note is bracketed to allow inclusion for our future use. There are two notes at the end of the drug schedule addressing diabetic and asthmatic supplies. Once is used with standard PPO plan, the other is used with HSA plan options. All of these notes are bracketed to allow them to be included or removed.
Schedule of Benefits	Prescription Drugs – Oral Chemotherapy	There are two option notes. One is for use with standard (Non-HSA plans). The other is only used with HSA plans.
How Your Plan Works	Guest Memberships	This is a Blue Cross Blue Shield program applicable to HMOs. It will only be offered with off-exchange HMO plans.
How Your Plan Works	Patient-Centered Primary Care Program	Patient-Centered Primary Care Program (PC2) is an optional language that we have included for future use.
How Your Plan Works	Crediting Prior Plan Coverage	This option is only available for off-exchange plans
How Your Plan Works	BlueCard Program	Phone numbers and URL address bracketed for future changes if this information is revised.

Section	Subsection(s)/ Provision(s)	Variable Use
What's Covered	Maternity and Reproductive Health Services	Options within this benefit are as follows: • Contraceptive benefit – Although standard, this benefit is filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements. • Sterilization benefit – Although also standard, this benefit is also filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements.
What's Covered	Preventive Care	Item 4.a. (contraceptives) Although standard, this benefit is filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care Item 4.b. (Breast pumps). Per pregnancy and per benefit period options are bracketed to allow for inclusion or removal.
What's Covered	Surgery – Bariatric Surgery	The bariatric surgery benefit is bracketed to either be included or be removed in its entirety depending if a small groups opts to include this benefit per state mandate.
Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy	Covered Prescription Drugs	Contraceptives item is bracketed to allow for removal in its entirety at request of group or member due to religious objections.
Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy	Special Programs	Language is bracketed to allow for inclusion or removal depending if an HSA plan is selected.
What's Not Covered	All bracketed exclusions	Exclusions within this section that are bracketed will either be included or removed in their entirety for: Contraceptives - Although normally covered, we will allow a religious group that qualifies for an exemption from the federal Women's Preventive Care requirement to remove this coverage. Sterilization - Like contraceptives, this option is included only for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements. Weight Loss Programs - The last sentence in this exclusion is bracketed to either be included or be removed in its entirety depending if a small groups opts to not cover bariatric surgery per state mandate. Weight Loss Surgery - This exclusion is bracketed to either be included or be removed in its entirety depending if a small groups opts to not cover bariatric surgery per state mandate.

Section	Subsection(s)/ Provision(s)	Variable Use
		Under prescription Drug exclusions: Clinically-Equivalent Alternatives - This is an optional exclusion. Although we do not plan to use this exclusion at this time, it has been filed as optional in case we wish to use it in the future. Contraceptives - As with the medical benefit exclusion noted above, this item is bracketed to allow for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements.
Coordination of Benefits	COB Definitions	Definition of plan includes an option to carve out Medicare.
Grievance and External Review Procedures	Grievances	Addresses and phone numbers are bracketed to allow for future change.
Grievance and External Review Procedures	Appeals by Members of ERISA Plans	Section is bracketed to allow for removal in the event group is not subject to ERISA.
Eligibility and Enrollment – Adding Members	Dependents	Domestic Partner language and subsequent references to domestic partners throughout eligibility section is filed bracketed to allow for inclusion or removal dependent upon a group wanting to implement this. There are also options for coverage to be same sex only, opposite sex only, or both.
Eligibility and Enrollment – Adding Members	Open Enrollment	References to open enrollment have been bracketed throughout the Eligibility section so they can be removed if open enrollment isn't offered. The standard option, however, will be to include open enrollment.
Definitions	Open Enrollment	Open enrollment is filed bracketed to allow for inclusion or removal.

STATEMENT OF VARIABILITY
Small Group POS–On Exchange Product
For Certificate Form ABCBS-SG POS-ON-OFF EXCH-v02

General Variable Information

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Specific Variable Information

The following is an explanation of the variables used within this certificate form.

Section	Subsection(s)/ Provision(s)	Variable Use
Front Cover		Anthem Logo and Company address is bracketed to allow for future change. The following note only appears in certificates for on exchange plans: If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.
Additional Federal Notices	Statement of ERISA Rights	The entire subsection is bracketed to allow for inclusion or removal depending if group is subject to ERISA.
Notices Required by State Law	Notice to Members	Phone number is bracketed to allow for future change.
Introduction	Company president signature	Company president signature is bracketed to allow for future change.

Section	Subsection(s)/ Provision(s)	Variable Use
Schedule of Benefits	Benefit Period	On exchange plans only have option for Calendar year. Off-exchange plans can offer both calendar year & Plan year.
Schedule of Benefits	Surgery	The bariatric surgery benefit is bracketed to either be included or be removed in its entirety depending if a small groups opts to include this benefit per state mandate.
Schedule of Benefits	Prescription Drugs	Brand penalty note is bracketed to allow inclusion for our future use.
How Your Plan Works	Patient-Centered Primary Care Program	Patient-Centered Primary Care Program (PC2) is an optional language that we have included for future use.
How Your Plan Works	Crediting Prior Plan Coverage	This option is only available for off-exchange plans
How Your Plan Works	BlueCard Program	Phone numbers and URL address bracketed for future changes if this information is revised.
What's Covered	Maternity and Reproductive Health Services	Options within this benefit are as follows: • Contraceptive benefit – Although standard, this benefit is filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements. • Sterilization benefit – Although also standard, this benefit is also filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements.
What's Covered	Preventive Care	Item 4.a. (contraceptives) Although standard, this benefit is filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care Item 4.b. (Breast pumps). Per pregnancy and per benefit period options are bracketed to allow for inclusion or removal.
What's Covered	Surgery – Bariatric Surgery	The bariatric surgery benefit is bracketed to either be included or be removed in its entirety depending if a small groups opts to include this benefit per state mandate.
Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy	Covered Prescription Drugs	Contraceptives item is bracketed to allow for removal in its entirety at request of group or member due to religious objections.
What's Not Covered	All bracketed exclusions	Exclusions within this section that are bracketed will either be included or removed in their entirety for: Contraceptives - Although normally covered, we will allow a religious group that qualifies for an exemption from the federal Women's Preventive Care requirement to remove this coverage. Sterilization - Like contraceptives, this option is included only for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements. Weight Loss Programs - The last sentence in this exclusion is

Section	Subsection(s)/ Provision(s)	Variable Use
		bracketed to either be included or be removed in its entirety depending if a small groups opts to not cover bariatric surgery per state mandate. Weight Loss Surgery - This exclusion is bracketed to either be included or be removed in its entirety depending if a small groups opts to not cover bariatric surgery per state mandate. Under prescription Drug exclusions: Clinically-Equivalent Alternatives - This is an optional exclusion. Although we do not plan to use this exclusion at this time, it has been filed as optional in case we wish to use it in the future. Contraceptives - As with the medical benefit exclusion noted above, this item is bracketed to allow for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements.
Coordination of Benefits	COB Definitions	Definition of plan includes an option to carve out Medicare.
Grievance and External Review Procedures	Grievances	Addresses and phone numbers are bracketed to allow for future change.
Grievance and External Review Procedures	Appeals by Members of ERISA Plans	Section is bracketed to allow for removal in the event group is not subject to ERISA.
Eligibility and Enrollment – Adding Members	Dependents	Domestic Partner language and subsequent references to domestic partners throughout eligibility section is filed bracketed to allow for inclusion or removal dependent upon a group wanting to implement this. There are also options for coverage to be same sex only, opposite sex only, or both.
Eligibility and Enrollment – Adding Members	Open Enrollment	References to open enrollment have been bracketed throughout the Eligibility section so they can be removed if open enrollment isn't offered. The standard option, however, will be to include open enrollment.
Definitions	Open Enrollment	Open enrollment is filed bracketed to allow for inclusion or removal.

STATEMENT OF VARIABILITY
Small Group PPO–Off-Exchange Product
For Certificate Form ABCBS-SG PPO OFF EXCH-v02

General Variable Information

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Please note that the deductible, out of pocket and cost shares value ranges bracketed in the schedule will only be arranged to match our companies small group benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

Specific Variable Information

The following is an explanation of the variables used within this certificate form.

Section	Subsection(s)/ Provision(s)	Variable Use
Front Cover		Product Names are bracketed to allow for different names to appear depending on a group's benefit selection. Anthem Logo and Company address is bracketed to allow for future change.
Additional Federal Notices	Statement of ERISA Rights	The entire subsection is bracketed to allow for inclusion or removal depending if group is subject to ERISA.
Notices Required by State Law	Notice to Members	Phone number is bracketed to allow for future change.
Introduction	High-Deductible Health Plan for Use with Health Savings Accounts	The entire subsection is bracketed to allow for inclusion or removal depending if group has an HSA product.
Introduction	Company president signature	Company president signature is bracketed to allow for future change.

STATEMENT OF VARIABILITY
Small Group PPO–Off-Exchange Product
For Certificate Form ABCBS-SG PPO OFF EXCH-v02

Section	Subsection(s)/ Provision(s)	Variable Use
Schedule of Benefits	Benefit Period	Calendar year is standard. However, we have also included an option for plan year.
Schedule of Benefits	Deductible	Deductible amount option ranges are as shown in schedule. Standardly we include both member & family deductibles. However, we also have “Non-Embedded” plan options available for our HSA plans. The paragraph applicable to those plans in brackets would be included.
Schedule of Benefits	Coinsurance	Coinsurance amount ranges are as shown in schedule.
Schedule of Benefits	Out-of-Pocket Limit	Standardly we include both member & family Out of Pocket. Standardly we include both member & family deductibles. However, we also have “Non-Embedded” plan options available for our HSA plans. The paragraph applicable to those plans in brackets would be included.
Schedule of Benefits	Ambulance Services (Land / Air)	Cost Share options ranges are as shown in the schedule. Optional selections depending if deductible is waived or if it applies.
Schedule of Benefits	Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies	Cost Share options ranges are as shown in the schedule. Optional selections depending if deductible is waived or if it applies.
Schedule of Benefits	Emergency Room Services	Cost Share options ranges are as shown in the schedule. Also within brackets Copayment can be waived if admitted. Optional selections depending if deductible is waived or if it applies.
Schedule of Benefits	Home Care Services	Cost Share options ranges are as shown in the schedule. Optional selections depending if deductible is waived or if it applies.
Schedule of Benefits	Hospice Care	Cost Share options ranges are as shown in the schedule. Optional selections depending if deductible is waived or if it applies.
Schedule of Benefits	Inpatient Services (Facility and professional services)	Cost Share options ranges are as shown in the schedule. Preferred Vendors- options are bracketed to allow Group to select a Preferred Vendor. Optional selections depending if deductible is waived or if it applies.

STATEMENT OF VARIABILITY
Small Group PPO–Off-Exchange Product
For Certificate Form ABCBS-SG PPO OFF EXCH-v02

Section	Subsection(s)/ Provision(s)	Variable Use
Schedule of Benefits (CONT)	Inpatient Services (Facility and professional services) (CONT)	There are optional sentences included in brackets for products that include hospital flat (\$) dollar copayments. Language is bracketed to either include or remove. If a product is selected that includes a flat (\$) dollar copayments, this language will be included.
Schedule of Benefits	Maternity Services	Cost Share options ranges are as shown in the schedule. We also include optional notes depending if Copayment applies. Optional selections depending if deductible is waived or if it applies.
Schedule of Benefits	Mental Health and Substance Abuse Services	Cost Share options ranges are as shown in the schedule. Preferred Vendors- options are bracketed to allow Group to select a Preferred Vendor. Optional selections depending if deductible is waived or if it applies.
Schedule of Benefits	Office Visits	Cost Share options ranges are as shown in the schedule. Optional selections depending if deductible is waived or if it applies. Preferred Vendors- options are bracketed to allow Group to select a Preferred Vendor. There is an optional note applicable should a Group select the option of 3 visit verbiage.
Schedule of Benefits	Outpatient Facility Services	Cost Share options ranges are as shown in the schedule. Optional selections depending if deductible is waived or if it applies. Preferred Vendors- options are bracketed to allow Group to select a Preferred Vendor.
Schedule of Benefits	Surgery	The bariatric surgery benefit is bracketed to either be included or be removed in its entirety depending if a small groups opts to include this benefit per state mandate.
Schedule of Benefits	Urgent Care Services	Cost Share options ranges are as shown in the schedule. Optional selections depending if deductible is waived or if it applies.
Schedule of Benefits	Human Organ and Tissue transplant (HOTT) services	Cost Share options for standard plans and HSA plans are as shown in the schedule.

STATEMENT OF VARIABILITY
Small Group PPO–Off-Exchange Product
For Certificate Form ABCBS-SG PPO OFF EXCH-v02

Section	Subsection(s)/ Provision(s)	Variable Use
Schedule of Benefits	Prescription Drugs	The prescription drug deductible provision is bracketed for use with some of our plan offerings. The entire provision is included or removed depending on the benefit plan selected. It is also not used with HSA plans. The note applicable to this provision in brackets will only be included for 2014 plan year per guidance that drug deductibles do not have to apply toward overall plan deductible. Prescription drug Cost Share options are as shown in the schedule. Brand penalty note is bracketed to allow inclusion for our future use. There are two notes at the end of the drug schedule addressing diabetic and asthmatic supplies. One is used with standard PPO plan, the other is used with HSA plan options. All of these notes are bracketed to allow them to be included or removed.
Schedule of Benefits	Prescription Drugs – Oral Chemotherapy	There are two option notes. One is for use with standard (Non-HSA plans). The other is only used with HSA plans.
How Your Plan Works	Enhanced Personal Health Care Program	Enhanced Personal Health Care Program (PC2) is an optional language that we have included for future use.
How Your Plan Works	BlueCard Program	Phone numbers and URL address bracketed for future changes if this information is revised.
What's Covered	Orthodontic Care	Optional section for Ortho/Dental Necessity. This option is available for use should the Group select this option.
What's Covered	Maternity and Reproductive Health Services	Options within this benefit are as follows: • Contraceptive benefit – Although standard, this benefit is filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements. • Sterilization benefit – Although also standard, this benefit is also filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements.
What's Covered	Preventive Care	Item 4.a. (contraceptives) Although standard, this benefit is filed as optional so we can remove it for religious groups who qualify for an opt out of the federal Women's Preventive Care Item 4.b. (Breast pumps). Per pregnancy and per benefit period options are bracketed to allow for inclusion or removal.

STATEMENT OF VARIABILITY
Small Group PPO–Off-Exchange Product
For Certificate Form ABCBS-SG PPO OFF EXCH-v02

Section	Subsection(s)/ Provision(s)	Variable Use
What's Covered	Surgery – Bariatric Surgery	The bariatric surgery benefit is bracketed to either be included or be removed in its entirety depending if a small groups opts to include this benefit per state mandate.
Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy	Covered Prescription Drugs	Contraceptives item is bracketed to allow for removal in its entirety at request of group or member due to religious objections.
Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy	Special Programs	Language is bracketed to allow for inclusion or removal depending if an HSA plan is selected.
What's Not Covered	All bracketed exclusions	Exclusions within this section that are bracketed will either be included or removed in their entirety for: Contraceptives - Although normally covered, we will allow a religious group that qualifies for an exemption from the federal Women's Preventive Care requirement to remove this coverage. Sterilization - Like contraceptives, this option is included only for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements. Weight Loss Programs - The last sentence in this exclusion is bracketed to either be included or be removed in its entirety depending if a small groups opts to not cover bariatric surgery per state mandate. Weight Loss Surgery - This exclusion is bracketed to either be included or be removed in its entirety depending if a small groups opts to not cover bariatric surgery per state mandate. Under prescription Drug exclusions: Clinically-Equivalent Alternatives - This is an optional exclusion. Although we do not plan to use this exclusion at this time, it has been filed as optional in case we wish to use it in the future. Contraceptives - As with the medical benefit exclusion noted above, this item is bracketed to allow for religious groups who qualify for an opt out of the federal Women's Preventive Care requirements.
Coordination of Benefits	COB Definitions	Definition of plan includes an option to carve out Medicare.

STATEMENT OF VARIABILITY
Small Group PPO–Off-Exchange Product
For Certificate Form ABCBS-SG PPO OFF EXCH-v02

Section	Subsection(s)/ Provision(s)	Variable Use
Coordination of Benefits	COB non-Allowable expenses	Item 7. Has been bracketed to allow removal should a Group not select Prescription Drug coverage.
Grievance and External Review Procedures	Grievances	Addresses and phone numbers are bracketed to allow for future change.
Grievance and External Review Procedures	Grievances and Appeals by Members of ERISA Plans	Section is bracketed to allow for removal in the event group is not subject to ERISA.
Eligibility and Enrollment – Adding Members	Dependents	Domestic Partner language and subsequent references to domestic partners throughout eligibility section is filed bracketed to allow for inclusion or removal dependent upon a group wanting to implement this. There are also options for coverage to be same sex only, opposite sex only, or both. In addition, should an affidavit be used, these sections can be included.
Eligibility and Enrollment – Adding Members	Open Enrollment	References to open enrollment have been bracketed throughout the Eligibility section so they can be removed if open enrollment isn't offered. The standard option, however, will be to include open enrollment.
Definitions	Open Enrollment	Open enrollment is filed bracketed to allow for inclusion or removal.

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana’s benchmark plan are “essential health benefits” (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer’s Policy			
Primary Care Visit to Treat an Injury or Illness	See Page		of	
Specialist Visit	See Page		of	
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page		of	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page		of	
Outpatient Surgery Physician/Surgical Services	See Page		of	
Hospice Services	See Page		of	
Private-Duty Nursing	See Page		of	
Urgent Care Centers or Facilities	See Page		of	
Home Health Care Services	See Page		of	
Emergency Room Services	See Page		of	
Emergency Transportation/Ambulance	See Page		of	
Inpatient Hospital Services (e.g., Hospital Stay)	See Page		of	
Inpatient Physician and Surgical Services	See Page		of	
Skilled Nursing Facility	See Page		of	
Prenatal and Postnatal Care	See Page		of	
Delivery and All Inpatient Services for Maternity Care	See Page		of	
Mental/Behavioral Health Outpatient Services	See Page		of	
Mental/Behavioral Health Inpatient Services	See Page		of	
Substance Abuse Disorder Outpatient Services	See Page		of	
Substance Abuse Disorder Inpatient Services	See Page		of	
Generic Drugs	See Page		of	
Preferred Brand Drugs	See Page		of	
Non-Preferred Brand Drugs	See Page		of	
Specialty Drugs	See Page		of	
Outpatient Rehabilitation Services	See Page		of	
Habilitation Services	See Page		of	
Chiropractic Care	See Page		of	
Durable Medical Equipment	See Page		of	
Imaging (CT/PET Scans, MRIs)	See Page		of	
Preventive Care/Screening/Immunization	See Page		of	

Indiana Department of Insurance

Routine Eye Exam for Children	See Page		of	
Eye Glasses for Children	See Page		of	
Dental Check-Up for Children	See Page		of	
Rehabilitative Speech Therapy	See Page		of	
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page		of	
Well Baby Visits and Care	See Page		of	
Laboratory Outpatient and Professional Services	See Page		of	
X-rays and Diagnostic Imaging	See Page		of	
Basic Dental Care – Child	See Page		of	
Orthodontia – Child	See Page		of	
Major Dental Care – Child	See Page		of	
Transplant	See Page		of	
Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
Nutritional Counseling	See Page		of	
Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

I, on behalf of _____ hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by _____ for review and approval.

Name: _____

Title: _____

Date: _____

Essential Health Benefits (EHB) Crosswalk and Certification Tool

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Benefit	Location of Benefit in Issuer’s Policy			
Primary Care Visit to Treat an Injury or Illness	See Page		of	
Specialist Visit	See Page		of	
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page		of	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page		of	
Outpatient Surgery Physician/Surgical Services	See Page		of	
Hospice Services	See Page		of	
Private-Duty Nursing	See Page		of	
Urgent Care Centers or Facilities	See Page		of	
Home Health Care Services	See Page		of	
Emergency Room Services	See Page		of	
Emergency Transportation/Ambulance	See Page		of	
Inpatient Hospital Services (e.g., Hospital Stay)	See Page		of	
Inpatient Physician and Surgical Services	See Page		of	
Skilled Nursing Facility	See Page		of	
Prenatal and Postnatal Care	See Page		of	
Delivery and All Inpatient Services for Maternity Care	See Page		of	
Mental/Behavioral Health Outpatient Services	See Page		of	
Mental/Behavioral Health Inpatient Services	See Page		of	
Substance Abuse Disorder Outpatient Services	See Page		of	
Substance Abuse Disorder Inpatient Services	See Page		of	
Generic Drugs	See Page		of	
Preferred Brand Drugs	See Page		of	
Non-Preferred Brand Drugs	See Page		of	
Specialty Drugs	See Page		of	
Outpatient Rehabilitation Services	See Page		of	
Habilitation Services	See Page		of	
Chiropractic Care	See Page		of	
Durable Medical Equipment	See Page		of	
Imaging (CT/PET Scans, MRIs)	See Page		of	
Preventive Care/Screening/Immunization	See Page		of	

Indiana Department of Insurance

Routine Eye Exam for Children	See Page		of	
Eye Glasses for Children	See Page		of	
Dental Check-Up for Children	See Page		of	
Rehabilitative Speech Therapy	See Page		of	
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page		of	
Well Baby Visits and Care	See Page		of	
Laboratory Outpatient and Professional Services	See Page		of	
X-rays and Diagnostic Imaging	See Page		of	
Basic Dental Care – Child	See Page		of	
Orthodontia – Child	See Page		of	
Major Dental Care – Child	See Page		of	
Transplant	See Page		of	
Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
Nutritional Counseling	See Page		of	
Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

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Name: _____

Title: _____

Date: _____

Essential Health Benefits (EHB) Crosswalk and Certification Tool

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Benefit	Location of Benefit in Issuer’s Policy			
Primary Care Visit to Treat an Injury or Illness	See Page		of	
Specialist Visit	See Page		of	
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page		of	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page		of	
Outpatient Surgery Physician/Surgical Services	See Page		of	
Hospice Services	See Page		of	
Private-Duty Nursing	See Page		of	
Urgent Care Centers or Facilities	See Page		of	
Home Health Care Services	See Page		of	
Emergency Room Services	See Page		of	
Emergency Transportation/Ambulance	See Page		of	
Inpatient Hospital Services (e.g., Hospital Stay)	See Page		of	
Inpatient Physician and Surgical Services	See Page		of	
Skilled Nursing Facility	See Page		of	
Prenatal and Postnatal Care	See Page		of	
Delivery and All Inpatient Services for Maternity Care	See Page		of	
Mental/Behavioral Health Outpatient Services	See Page		of	
Mental/Behavioral Health Inpatient Services	See Page		of	
Substance Abuse Disorder Outpatient Services	See Page		of	
Substance Abuse Disorder Inpatient Services	See Page		of	
Generic Drugs	See Page		of	
Preferred Brand Drugs	See Page		of	
Non-Preferred Brand Drugs	See Page		of	
Specialty Drugs	See Page		of	
Outpatient Rehabilitation Services	See Page		of	
Habilitation Services	See Page		of	
Chiropractic Care	See Page		of	
Durable Medical Equipment	See Page		of	
Imaging (CT/PET Scans, MRIs)	See Page		of	
Preventive Care/Screening/Immunization	See Page		of	

Indiana Department of Insurance

Routine Eye Exam for Children	See Page		of	
Eye Glasses for Children	See Page		of	
Dental Check-Up for Children	See Page		of	
Rehabilitative Speech Therapy	See Page		of	
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page		of	
Well Baby Visits and Care	See Page		of	
Laboratory Outpatient and Professional Services	See Page		of	
X-rays and Diagnostic Imaging	See Page		of	
Basic Dental Care – Child	See Page		of	
Orthodontia – Child	See Page		of	
Major Dental Care – Child	See Page		of	
Transplant	See Page		of	
Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
Nutritional Counseling	See Page		of	
Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

I, on behalf of _____ hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by _____ for review and approval.

Name: _____

Title: _____

Date: _____

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN072
HIOS Plan ID: 17575IN0720008

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$3,000.00	\$250.00				
Coinsurance (% ,Insurer's Cost Share)	80.00%	\$1.00				
OOP Maximum (\$)	\$4,500.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	78%		☒	☒		
Specialist Visit	☒	☒	79%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	78%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒	75%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	62%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	70%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 68.4%
Metal Tier: Silver
\$3,518.42
\$5,146.76

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.690241259
3552.506101
5146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN072
HIOS Plan ID: 17575IN0720009

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$2,000.00	\$250.00				
Coinsurance (% ,Insurer's Cost Share)	70.00%	\$1.00				
OOP Maximum (\$)	\$5,500.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	72%		☒	☒		
Specialist Visit	☒	☒	73%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	70%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒	67%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	52%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	70%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 68.7%
Metal Tier: Silver
\$3,537.82
\$5,146.76

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.688691492
3544.529824
5146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN072
HIOS Plan ID: 17575IN0720010

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$6,000.00	\$250.00				
Coinsurance (% , Insurer's Cost Share)	70.00%	\$1.00				
OOP Maximum (\$)	\$6,600.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	56%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	58%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	73%		☒	☒		
Specialist Visit	☒	☒	73%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	61%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	62%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	67%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	51%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒	60%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			66%		☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	70%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 62.5%
Metal Tier:

\$3,111.19
\$4,976.71

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.616227463
3066.785376
4976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN073
HIOS Plan ID: 17575IN0730003

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$6,000.00	\$250.00				
Coinsurance (% ,Insurer's Cost Share)	70.00%	\$1.00				
OOP Maximum (\$)	\$6,600.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	56%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	58%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	73%		☒	☒		
Specialist Visit	☒	☒	73%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	61%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	62%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	67%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	51%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒	60%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			66%		☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	70%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 62.5%
Metal Tier:

\$3,111.19
\$4,976.71

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.616227463
3066.785376
4976.71

HIOS Issuer ID:
HIOS Product ID:
HIOS Plan ID:

17575
17575IN072
17575IN0720011

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?
Apply Inpatient Copay per Day?
Apply Skilled Nursing Facility Copay per Day?
Use Separate OOP Maximum for Medical and Drug Spending?
Indicate if Plan Meets CSR Standard?
Desired Metal Tier

☒
☐
☐
☐
☐
Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$1,300.00			
Coinsurance (% Insurer's Cost Share)			90.00%			
OOP Maximum (\$)			\$6,000.00			
OOP Maximum if Separate (\$)						

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	Tier 1				Tier 2			
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒			☒	☒		
Specialist Visit	☒	☒			☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒			☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒			☒	☒		
Preferred Brand Drugs	☒	☒			☒	☒		
Non-Preferred Brand Drugs	☒	☒			☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒			☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful.
78.0%
Gold
\$4,214.94
\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740007

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$5,900.00	\$500.00				
Coinsurance (% ,Insurer's Cost Share)	100.00%	\$1.00				
OOP Maximum (\$)	\$6,600.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	82%		☒	☒		
Specialist Visit	☒	☒	88%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	92%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒	89%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	77%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	70%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 63.6%
Metal Tier:
\$3,163.30
\$4,976.71

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.618437128
3077.782238
4976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740008

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$1,000.00	\$0.00				
Coinsurance (% ,Insurer's Cost Share)	80.00%	\$1.00				
OOP Maximum (\$)	\$3,000.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	83%		☒	☒		
Specialist Visit	☒	☒	83%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	81%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒	80%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	70%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☐	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☐	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☐	☒	70%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 78.9%
Metal Tier: Gold
\$4,264.01
\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740009

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$2,500.00	\$500.00				
Coinsurance (% ,Insurer's Cost Share)	80.00%	\$1.00				
OOP Maximum (\$)	\$6,350.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	68%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$30.00	☒	☒		
Specialist Visit	☐	☐		\$60.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	75%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$30.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$30.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	70%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 71.6%
Metal Tier: Silver
\$3,684.28
\$5,146.76

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.702136082
3613.725902
5146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740010

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$5,000.00			
Coinsurance (% , Insurer's Cost Share)			80.00%			
OOP Maximum (\$)			\$6,350.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$30.00	☒	☒		
Specialist Visit	☒	☐		\$60.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	99%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒	66%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 58.7%
Metal Tier: Bronze
\$2,922.67
\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740011

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$5,000.00			
Coinsurance (% , Insurer's Cost Share)			50.00%			
OOP Maximum (\$)			\$6,350.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$50.00	☒	☒		
Specialist Visit	☒	☐		\$75.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	97%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒	49%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$50.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$90.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒			☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 59.3%
Metal Tier: Bronze
\$2,951.88
\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740012

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☒
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$2,000.00			
Coinsurance (% , Insurer's Cost Share)			70.00%			
OOP Maximum (\$)			\$4,500.00			
OOP Maximum if Separate (\$)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$20.00	☒	☒		
Specialist Visit	☒	☐		\$35.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	98%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	75%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒			☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?

☐

Set a Maximum on Specialty Rx Coinsurance Payments?

Specialty Rx Coinsurance Maximum:

☐

Set a Maximum Number of Days for Charging an IP Copay?

Days (1-10):

☐

Begin Primary Care Cost-Sharing After a Set Number of Visits?

Visits (1-10):

☐

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?

Copays (1-10):

☐

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

69.2%

Metal Tier:

Silver

\$3,563.10

\$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740013

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☒
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$2,000.00			
Coinsurance (% , Insurer's Cost Share)			99.99%			
OOP Maximum (\$)			\$2,000.00			
OOP Maximum if Separate (\$)						

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	100%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	100%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	100%		☒	☒		
Specialist Visit	☒	☒	100%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	100%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	100%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	100%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	100%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒	100%		☒	☒		
X-rays and Diagnostic Imaging	☒	☒	100%		☒	☒		
Skilled Nursing Facility	☒	☒	100%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			100%		☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	100%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒	100%		☒	☒		
Preferred Brand Drugs	☒	☒	100%		☒	☒		
Non-Preferred Brand Drugs	☒	☒	100%		☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	100%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

78.8%

Metal Tier:

Gold

\$4,258.30

\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740014

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$3,000.00			
Coinsurance (% ,Insurer's Cost Share)			99.99%			
OOP Maximum (\$)			\$3,000.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	100%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	100%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	100%		☒	☒		
Specialist Visit	☒	☒	100%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	100%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	100%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	100%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	100%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒	100%		☒	☒		
X-rays and Diagnostic Imaging	☒	☒	100%		☒	☒		
Skilled Nursing Facility	☒	☒	100%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			100%					
Outpatient Surgery Physician/Surgical Services	☒	☒	100%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒	100%		☒	☒		
Preferred Brand Drugs	☒	☒	100%		☒	☒		
Non-Preferred Brand Drugs	☒	☒	100%		☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	100%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 71.7%
Metal Tier: Silver
\$3,690.13
\$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740015

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$0.00				
Coinsurance (% ,Insurer's Cost Share)	70.00%	\$1.00				
OOP Maximum (\$)	\$5,000.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	59%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$20.00	☒	☒		
Specialist Visit	☐	☐		\$40.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	82%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$20.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$20.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	74%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$10.00	☒	☒		
Preferred Brand Drugs	☐	☐		\$30.00	☒	☒		
Non-Preferred Brand Drugs	☐	☐		\$60.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☐	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 78.5%
Metal Tier: Gold
\$4,243.30
\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740016

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Gold

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
Deductible (\$)	\$3,500.00	\$0.00
Coinsurance (% ,Insurer's Cost Share)	100.00%	\$1.00
OOP Maximum (\$)	\$4,000.00	
OOP Maximum If Separate (\$)		

Tier 2 Plan Benefit Design		
Medical	Drug	Combined

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☐		\$200.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☐	☐		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$20.00	☒	☒		
Specialist Visit	☐	☐		\$40.00	☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	84%		☐	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☐	☒		
Rehabilitative Speech Therapy	☐	☐		\$20.00	☐	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$20.00	☐	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☐	☒		
X-rays and Diagnostic Imaging	☒	☒			☐	☒		
Skilled Nursing Facility	☒	☒			☐	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☐	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	88%		☐	☒		
Drugs	☒ All	☒ All			☐ All	☒ All		
Generics	☐	☐		\$10.00	☐	☒		
Preferred Brand Drugs	☐	☐		\$30.00	☐	☒		
Non-Preferred Brand Drugs	☐	☐		\$60.00	☐	☒		
Specialty Drugs (i.e. high-cost)	☐	☒	75%		☐	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 79.5%
Metal Tier: Gold
\$4,292.93
\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740017

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☐
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$0.00				
Coinsurance (% ,Insurer's Cost Share)	70.00%	\$1.00				
OOP Maximum (\$)	\$4,000.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	59%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$10.00	☒	☒		
Specialist Visit	☐	☐		\$35.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	90%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$10.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$10.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	75%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$10.00	☒	☒		
Preferred Brand Drugs	☐	☐		\$30.00	☒	☒		
Non-Preferred Brand Drugs	☐	☐		\$60.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☐	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

81.0%

Metal Tier:

Gold

\$4,378.01

\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740018

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$2,500.00	\$0.00				
Coinsurance (% , Insurer's Cost Share)	80.00%	\$1.00				
OOP Maximum (\$)	\$4,500.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	68%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$20.00	☒	☒		
Specialist Visit	☐	☐		\$40.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	83%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$20.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$20.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	77%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$10.00	☒	☒		
Preferred Brand Drugs	☐	☐		\$30.00	☒	☒		
Non-Preferred Brand Drugs	☐	☐		\$60.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☐	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 79.0%
Metal Tier: Gold
\$4,266.52
\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740019

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$1,000.00	\$500.00				
Coinsurance (% ,Insurer's Cost Share)	80.00%	\$1.00				
OOP Maximum (\$)	\$3,500.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	68%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$25.00	☒	☒		
Specialist Visit	☐	☐		\$50.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	79%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$25.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$25.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	73%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$10.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$30.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$60.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 81.6%
Metal Tier: Gold
\$4,408.58
\$5,403.01

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.796487965
4303.432442
5403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740020

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☐
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$1,000.00	\$0.00				
Coinsurance (% ,Insurer's Cost Share)	80.00%	\$1.00				
OOP Maximum (\$)	\$5,000.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	69%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$10.00	☒	☒		
Specialist Visit	☐	☐		\$50.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	91%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$10.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$10.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	75%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$10.00	☒	☒		
Preferred Brand Drugs	☐	☐		\$30.00	☒	☒		
Non-Preferred Brand Drugs	☐	☐		\$60.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☐	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

80.1%

Metal Tier:

Gold

\$4,329.30

\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740021

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$4,000.00	\$250.00				
Coinsurance (% ,Insurer's Cost Share)	80.00%	\$1.00				
OOP Maximum (\$)	\$6,600.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	67%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$40.00	☒	☒		
Specialist Visit	☐	☐		\$60.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	66%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$40.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$40.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	70%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 72.8%
Metal Tier:

\$3,744.68
\$5,146.76

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.717384535
3692.20603
5146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740022

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$5,000.00	\$500.00				
Coinsurance (% ,Insurer's Cost Share)	80.00%	\$1.00				
OOP Maximum (\$)	\$6,350.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	66%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$40.00	☒	☒		
Specialist Visit	☐	☐		\$60.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	66%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$40.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$40.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	67%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 72.5%
Metal Tier:

\$3,730.03
\$5,146.76

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.699171392
3598.467352
5146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740023

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$2,000.00	\$0.00				
Coinsurance (% ,Insurer's Cost Share)	50.00%	\$1.00				
OOP Maximum (\$)	\$6,350.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☒	41%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$50.00	☒	☒		
Specialist Visit	☐	☐		\$75.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	57%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$50.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$50.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	54%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☐	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☐	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☐	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 71.4%
Metal Tier: Silver
\$3,673.68
\$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740024

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☐
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)	\$5,000.00	\$500.00				
Coinsurance (% ,Insurer's Cost Share)	100.00%	\$1.00				
OOP Maximum (\$)	\$6,000.00					
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☐	☐		\$250.00	☐	☐		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$40.00	☒	☒		
Specialist Visit	☐	☐		\$70.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☒	69%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☐	☐		\$40.00	☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		\$40.00	☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☐	☒	80%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☐	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☒
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	\$250
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Error: Result is outside of +/- 2 percent de minimis variation.
Actuarial Value: 74.0%

Metal Tier:
\$3,808.72
\$5,146.76

Reference Unique Justification Document for additional details on AV Adjustments used for this HIOS Plan ID
0.717854296
3694.623777
5146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740025

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$4,000.00			
Coinsurance (% , Insurer's Cost Share)			80.00%			
OOP Maximum (\$)			\$6,350.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒			☒	☒		
Specialist Visit	☒	☒			☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒			☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒			☒	☒		
Preferred Brand Drugs	☒	☒			☒	☒		
Non-Preferred Brand Drugs	☒	☒			☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒			☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 61.5%
Metal Tier: Bronze
\$3,061.27
\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740026

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☒
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Bronze

HSA/HRA Options

HSA/HRA Employer Contribution?

☐

Annual Contribution Amount:

Narrow Network Options

Blended Network/POS Plan?

☐

1st Tier Utilization:

2nd Tier Utilization:

Tier 1 Plan Benefit Design

Medical	Drug	Combined
		\$5,500.00
		99.99%
		\$5,500.00

Tier 2 Plan Benefit Design

Medical	Drug	Combined

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	100%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	100%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	100%		☒	☒		
Specialist Visit	☒	☒	100%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	100%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	100%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	100%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	100%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒	100%		☒	☒		
X-rays and Diagnostic Imaging	☒	☒	100%		☒	☒		
Skilled Nursing Facility	☒	☒	100%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			100%		☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	100%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒	100%		☒	☒		
Preferred Brand Drugs	☒	☒	100%		☒	☒		
Non-Preferred Brand Drugs	☒	☒	100%		☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	100%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?

☐

Set a Maximum on Specialty Rx Coinsurance Payments?

Specialty Rx Coinsurance Maximum:

☐

Set a Maximum Number of Days for Charging an IP Copay?

Days (1-10):

☐

Begin Primary Care Cost-Sharing After a Set Number of Visits?

Visits (1-10):

☐

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?

Copays (1-10):

☐

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

61.0%

Metal Tier:

Bronze

\$3,037.55

\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740027

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier: Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$3,000.00			
Coinsurance (% , Insurer's Cost Share)			50.00%			
OOP Maximum (\$)			\$6,350.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒			☒	☒		
Specialist Visit	☒	☒			☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒			☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒			☒	☒		
Preferred Brand Drugs	☒	☒			☒	☒		
Non-Preferred Brand Drugs	☒	☒			☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒			☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 60.6%
Metal Tier: Bronze
\$3,017.52
\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740028

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☒
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$6,300.00			
Coinsurance (% , Insurer's Cost Share)			99.99%			
OOP Maximum (\$)			\$6,300.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	100%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	100%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	100%		☒	☒		
Specialist Visit	☒	☒	100%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	100%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	100%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	100%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	100%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒	100%		☒	☒		
X-rays and Diagnostic Imaging	☒	☒	100%		☒	☒		
Skilled Nursing Facility	☒	☒	100%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			100%		☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	100%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒	100%		☒	☒		
Preferred Brand Drugs	☒	☒	100%		☒	☒		
Non-Preferred Brand Drugs	☒	☒	100%		☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	100%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?

☐

Set a Maximum on Specialty Rx Coinsurance Payments?

Specialty Rx Coinsurance Maximum:

☐

Set a Maximum Number of Days for Charging an IP Copay?

Days (1-10):

☐

Begin Primary Care Cost-Sharing After a Set Number of Visits?

Visits (1-10):

☐

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?

Copays (1-10):

☐

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

58.2%

Metal Tier:

Bronze

\$2,894.64

\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740029

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☒
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$4,500.00			
Coinsurance (% ,Insurer's Cost Share)			80.00%			
OOP Maximum (\$)			\$6,350.00			
OOP Maximum if Separate (\$)						

Click Here for Important Instructions

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒			☒	☒		
Specialist Visit	☒	☒			☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒			☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒			☒	☒		
Preferred Brand Drugs	☒	☒			☒	☒		
Non-Preferred Brand Drugs	☒	☒			☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒			☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?

☐

Set a Maximum on Specialty Rx Coinsurance Payments?

Specialty Rx Coinsurance Maximum:

☐

Set a Maximum Number of Days for Charging an IP Copay?

Days (1-10):

☐

Begin Primary Care Cost-Sharing After a Set Number of Visits?

Visits (1-10):

☐

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?

Copays (1-10):

☐

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

60.3%

Metal Tier:

Bronze

\$3,001.72

\$4,976.71

HIOS Issuer ID:17575

HIOS Product ID:17575IN074

HIOS Plan ID:17575IN0740030

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?☒
- Apply Inpatient Copay per Day?☐
- Apply Skilled Nursing Facility Copay per Day?☐
- Use Separate OOP Maximum for Medical and Drug Spending?☐
- Indicate if Plan Meets CSR Standard?☐
- Desired Metal Tier:Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$5,000.00			
Coinsurance (% ,Insurer's Cost Share)			80.00%			
OOP Maximum (\$)			\$6,350.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$30.00	☒	☒		
Specialist Visit	☒	☐		\$60.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	99%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒	66%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:Calculation Successful.

Actuarial Value:58.7%

Metal Tier:Bronze

\$2,922.67

\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740031

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☒
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
		\$3,500.00			
		80.00%			
		\$6,450.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$30.00	☒	☒		
Specialist Visit	☒	☐		\$60.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	99%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒	70%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

61.1%

Metal Tier:

Bronze

\$3,042.92

\$4,976.71

HIOS Issuer ID:
HIOS Product ID:
HIOS Plan ID:

17575
17575IN074
17575IN0740032

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?
Apply Inpatient Copay per Day?
Apply Skilled Nursing Facility Copay per Day?
Use Separate OOP Maximum for Medical and Drug Spending?
Indicate if Plan Meets CSR Standard?
Desired Metal Tier

☒
☐
☐
☐
☐
Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$4,500.00			
Coinsurance (% ,Insurer's Cost Share)			100.00%			
OOP Maximum (\$)			\$6,350.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$30.00	☒	☒		
Specialist Visit	☒	☐		\$60.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒			☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	82%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful.
59.8%
Bronze
\$2,976.46
\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740033

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☒
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Bronze

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
Medical	Drug	Combined	Medical	Drug	Combined
		\$4,500.00			
		70.00%			
		\$6,350.00			

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$50.00	☒	☒		
Specialist Visit	☒	☐		\$75.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	98%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	56%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$50.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$90.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒			☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

59.1%

Metal Tier:

Bronze

\$2,943.47

\$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740034

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?

☒
- Apply Inpatient Copay per Day?

☐
- Apply Skilled Nursing Facility Copay per Day?

☐
- Use Separate OOP Maximum for Medical and Drug Spending?

☐
- Indicate if Plan Meets CSR Standard?

☐
- Desired Metal Tier

Gold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution?	Blended Network/POS Plan?
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$1,300.00			
Coinsurance (% ,Insurer's Cost Share)			90.00%			
OOP Maximum (\$)			\$2,250.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$10.00	☒	☒		
Specialist Visit	☒	☐		\$35.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	99%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	81%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$10.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$30.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$60.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:

Calculation Successful.

Actuarial Value:

78.5%

Metal Tier:

Gold

\$4,241.18

\$5,403.01

HIOS Issuer ID: 17575
 HIOS Product ID: 17575IN074
 HIOS Plan ID: 17575IN0740035

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
 Apply Inpatient Copay per Day? ☐
 Apply Skilled Nursing Facility Copay per Day? ☐
 Use Separate OOP Maximum for Medical and Drug Spending? ☐
 Indicate if Plan Meets CSR Standard? ☐
 Desired Metal Tier: Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☒	Blended Network/POS Plan?	☐
Annual Contribution Amount:	\$500.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$4,000.00			
Coinsurance (% ,Insurer's Cost Share)			100.00%			
OOP Maximum (\$)			\$5,000.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$30.00	☒	☒		
Specialist Visit	☒	☐		\$60.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒			☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)					☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	83%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost? ☐
 Set a Maximum on Specialty Rx Coinsurance Payments?
 Specialty Rx Coinsurance Maximum:
 Set a Maximum Number of Days for Charging an IP Copay? ☐
 # Days (1-10):
 Begin Primary Care Cost-Sharing After a Set Number of Visits? ☐
 # Visits (1-10):
☐
 Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? ☐
 # Copays (1-10):

Output

Status/Error Messages: Calculation Successful.
 Actuarial Value: 69.8%
 Metal Tier: Silver
 \$3,593.90
 \$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740036

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$1,500.00			
Coinsurance (% , Insurer's Cost Share)			80.00%			
OOP Maximum (\$)			\$5,000.00			
OOP Maximum if Separate (\$)						

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☐		\$25.00	☒	☒		
Specialist Visit	☒	☐		\$40.00	☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	99%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒	78%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☐		\$15.00	☒	☒		
Preferred Brand Drugs	☒	☐		\$35.00	☒	☒		
Non-Preferred Brand Drugs	☒	☐		\$70.00	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	75%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 71.0%
Metal Tier: Silver
\$3,653.58
\$5,146.76

HIOS Issuer ID:17575

HIOS Product ID:17575IN074

HIOS Plan ID:17575IN0740037

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible?☒
- Apply Inpatient Copay per Day?☐
- Apply Skilled Nursing Facility Copay per Day?☐
- Use Separate OOP Maximum for Medical and Drug Spending?☐
- Indicate if Plan Meets CSR Standard?☐
- Desired Metal TierGold

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization:
	2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$2,000.00			
Coinsurance (% ,Insurer's Cost Share)			99.99%			
OOP Maximum (\$)			\$2,000.00			
OOP Maximum if Separate (\$)						

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Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	100%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	100%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	100%		☒	☒		
Specialist Visit	☒	☒	100%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	100%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	100%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	100%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	100%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒	100%		☒	☒		
X-rays and Diagnostic Imaging	☒	☒	100%		☒	☒		
Skilled Nursing Facility	☒	☒	100%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			100%		☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	100%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒	100%		☒	☒		
Preferred Brand Drugs	☒	☒	100%		☒	☒		
Non-Preferred Brand Drugs	☒	☒	100%		☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	100%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:Calculation Successful.

Actuarial Value:78.8%

Metal Tier:Gold

\$4,258.30

\$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740038

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$2,500.00			
Coinsurance (% ,Insurer's Cost Share)			80.00%			
OOP Maximum (\$)			\$4,500.00			
OOP Maximum if Separate (\$)						

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒			☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒			☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒			☒	☒		
Specialist Visit	☒	☒			☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒			☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒			☒	☒		
Rehabilitative Speech Therapy	☒	☒			☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒			☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒			☒	☒		
X-rays and Diagnostic Imaging	☒	☒			☒	☒		
Skilled Nursing Facility	☒	☒			☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services	☒	☒			☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒			☒	☒		
Preferred Brand Drugs	☒	☒			☒	☒		
Non-Preferred Brand Drugs	☒	☒			☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒			☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 68.4%
Metal Tier: Silver
\$3,517.94
\$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740039

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☒	Blended Network/POS Plan?	☐
Annual Contribution Amount:	\$750.00	1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design				Tier 2 Plan Benefit Design		
	Medical	Drug	Combined		Medical	Drug	Combined
Deductible (\$)			\$5,500.00				
Coinsurance (% , Insurer's Cost Share)			99.99%				
OOP Maximum (\$)			\$5,500.00				
OOP Maximum if Separate (\$)							

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	100%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	100%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	100%		☒	☒		
Specialist Visit	☒	☒	100%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	100%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	100%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	100%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	100%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒	100%		☒	☒		
X-rays and Diagnostic Imaging	☒	☒	100%		☒	☒		
Skilled Nursing Facility	☒	☒	100%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			100%		☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	100%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒	100%		☒	☒		
Preferred Brand Drugs	☒	☒	100%		☒	☒		
Non-Preferred Brand Drugs	☒	☒	100%		☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	100%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 69.7%
Metal Tier: Silver
\$3,588.96
\$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN074
HIOS Plan ID: 17575IN0740040

User Inputs for Plan Parameters

- Use Integrated Medical and Drug Deductible? ☒
Apply Inpatient Copay per Day? ☐
Apply Skilled Nursing Facility Copay per Day? ☐
Use Separate OOP Maximum for Medical and Drug Spending? ☐
Indicate if Plan Meets CSR Standard? ☐
Desired Metal Tier Silver

HSA/HRA Options	Narrow Network Options
HSA/HRA Employer Contribution? ☐	Blended Network/POS Plan? ☐
Annual Contribution Amount:	1st Tier Utilization: 2nd Tier Utilization:

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible (\$)			\$3,000.00			
Coinsurance (% , Insurer's Cost Share)			99.99%			
OOP Maximum (\$)			\$3,000.00			
OOP Maximum if Separate (\$)						

[Click Here for Important Instructions](#)

Type of Benefit	Tier 1				Tier 2			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All			☒ All	☒ All		
Emergency Room Services	☒	☒	100%		☒	☒		
All Inpatient Hospital Services (inc. MHSA)	☒	☒	100%		☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☒	☒	100%		☒	☒		
Specialist Visit	☒	☒	100%		☒	☒		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☒	☒	100%		☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒	100%		☒	☒		
Rehabilitative Speech Therapy	☒	☒	100%		☒	☒		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☒	☒	100%		☒	☒		
Preventive Care/Screening/Immunization			100%	\$0.00				
Laboratory Outpatient and Professional Services	☒	☒	100%		☒	☒		
X-rays and Diagnostic Imaging	☒	☒	100%		☒	☒		
Skilled Nursing Facility	☒	☒	100%		☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)			100%		☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒	100%		☒	☒		
Drugs	☒ All	☒ All			☒ All	☒ All		
Generics	☒	☒	100%		☒	☒		
Preferred Brand Drugs	☒	☒	100%		☒	☒		
Non-Preferred Brand Drugs	☒	☒	100%		☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒	100%		☒	☒		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages: Calculation Successful.
Actuarial Value: 71.7%
Metal Tier: Silver
\$3,690.13
\$5,146.76

SERFF Tracking #:

AWLP-129529740

State Tracking #:

ABCBS-SG HMO ON/OFF EXCH-V02

Company Tracking #:

State:

Indiana

Filing Company:

Anthem Insurance Companies, Inc.

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.003G Small Group Only - Other

Product Name:

IN 2015 - On- and Off-Exchange - SG

Project Name/Number:

/

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/06/2014		Form	PPO Certificate of Coverage	05/27/2014	Indiana SG ABCBS SG PPO OFF EXCH v02 clean 042914.pdf (Superseded)
05/06/2014		Form	HMO Certificate of Coverage	05/27/2014	Indiana ABCBS-SG HMO-ON-OFF EXCH-v02 clean.pdf (Superseded)
05/06/2014		Form	POS Certificate of Coverage	05/27/2014	Indiana SG ABCBS-SG POS-ON-OFF EXCH v02 clean.pdf (Superseded)
05/05/2014		Supporting Document	Redline Certificates of Coverage	05/22/2014	Indiana ABCBS-SG HMO-ON-OFF EXCH-v02 redline.pdf (Superseded) Indiana SG ABCBS-SG POS-ON-OFF EXCH v02 redline.pdf (Superseded) Indiana SG ABCBS SG PPO OFF EXCH v02 redline.pdf (Superseded)

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

**Anthem [Gold] [Silver] [Bronze] Blue Access PPO [Copayment or
Deductible/ Coinsurance/ Out-of-Pocket Limits] [Plus] [w/ HSA]**



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

Anthem Insurance Companies, Inc.

**[120 Monument Circle]
[Indianapolis, Indiana 46204]**

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, [\[www.anthem.com\]](http://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, [\[www.anthem.com\]](http://www.anthem.com)

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

[Use with HSAs:

High-Deductible Health Plan for Use with Health Savings Accounts

This Plan is meant to be federally tax qualified and used with a qualified health savings account. Approval by the **Indiana Department of Insurance** does not guarantee tax qualification and this Plan has not been submitted for approval by the IRS. Please seek the advice of a tax advisor.]

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.



[President]

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] [Plan Year]
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment- Adding Members" section for further details

Deductible	In-Network	Out-of-Network
Per Member	[\$1,000-\$6,300]	[\$2,000-\$12,600]
Per Family [– Aggregate/ Delete for non-embedded CDHP plans: All other Members combined]	[\$2,000-\$12,600]	[\$4,000-\$25,200]
[Option for Non-Embedded Plans (CDHP): If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amounts apply to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amounts apply.]) The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.		
Coinsurance	In-Network	Out-of-Network
Plan Pays	[100%-50%]	[70%-50%]
Member Pays	[0%-50%]	[30%-50%]
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		
Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	[\$2,000- \$6,600]	\$4,500- \$15,750]
Per Family [– Aggregate/ Delete for non-embedded CDHP plans: All other Members combined]	[\$4,000- \$13,200]	\$9,000- \$31,500]
[Option for Non-Embedded Plans: If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amounts apply to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amounts apply.] [Standard for plans with deductible, coinsurance and copays: The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.] [For plans that have deductible & coinsurance only, without copays: The Out-of-Pocket Limit includes all Deductibles and Coinsurance you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]		

Deductible	In-Network	Out-of-Network
The Out-of-Pocket Limit does not include amounts you pay for following benefits: Out-of-Network Human Organ and Tissue Transplant services. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional [Use for plans with deductible, coinsurance and copays: Deductibles, Coinsurance, or Copayments] [Use for plans with deductible and coinsurance only: Deductibles or Coinsurance] for the rest of the Benefit Period [, except for the services listed above]. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water) Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.	[\$100 Copayment] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Ambulance Services (Ground) Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.	[\$100 Copayment] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	

Benefits	In-Network	Out-of-Network
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	See “Mental Health and Substance Abuse Services.”	
Cardiac Rehabilitation	See “Therapy Services.”	
Chemotherapy	See “Therapy Services.”	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services for Members Through Age 18		
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• Diagnostic and Preventive Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Basic Restorative Services	40% Coinsurance after Deductible	50% Coinsurance after Deductible
• Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Dentally Necessary Orthodontic Care Waiting Period	12 months	

Benefits	In-Network	Out-of-Network
Dental Services (All Members / All Ages) Dental Services Accidental Injury Benefit Maximum Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that We are required to cover by law.	Benefits are based on the setting in which Covered Services are received. \$3,000 per Accidental Injury, In- and Out-of-Network combined	
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier) Wigs Needed After Cancer Treatment Benefit Maximum The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible One wig per Benefit Period, In- and Out-of-Network combined
Emergency Room Services Emergency Room - Emergency Room Facility Charge - Emergency Room Doctor Charge - Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	[\$200- \$250] Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [Copayment waived if admitted] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	

Benefits	In-Network	Out-of-Network
Advanced Diagnostic Imaging (including MRIs, CAT scans) Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.	[0%-50%] Coinsurance]	[no Deductible] [after Deductible]
Home Care		
Home Care Visits	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Dialysis	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Infusion Therapy	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Specialty Prescription Drugs	[\$10- \$50] Copayment] [per Drug] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Home Care Services / Supplies	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period, In- and Out-of-Network combined. The limit does not apply to Home Infusion Therapy or Home Dialysis.	
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period, In- and Out-of-Network combined 164 visits per Lifetime, In- and Out-of-Network combined	
Home Infusion Therapy	See "Home Care."	

Benefits	In-Network	Out-of-Network
Hospice Care - Home Care - Respite Hospital Stays		
	[No Copayment, Deductible, or Coinsurance] [0% Coinsurance] [no Deductible] [after Deductible]	[0%-50%] Coinsurance after Deductible
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Hospital / Acute Care Facility you will pay [0%-40%] Coinsurance] [no Deductible] [after Deductible]. [Please see [anthem.com] for a list of Preferred Facilities.]]		
Skilled Nursing Facility	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Skilled Nursing Facility you will pay [0%- 40%] Coinsurance] [no Deductible] [after Deductible]. [Please see [anthem.com] for a list of Preferred Facilities.]]		
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period, In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[For plans with hospital copay: Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.]		
[For plans with hospital copay: Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.]		

Benefits	In-Network	Out-of-Network
Doctor Services for: - General Medical Care / Evaluation and Management (E&M) - Surgery	[0%-50%] Coinsurance] [no Deductible] [after Deductible] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible [30%-50%] Coinsurance after Deductible
Maternity and Reproductive Health Services		
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal and delivery services) [Use only when copays apply: If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.]	[\$10- \$50] Copayment] [per pregnancy] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [Use only when OV copay applies: The Office Visit Copayment will also apply to the first prenatal visit.]	[30%-50%] Coinsurance after Deductible
Inpatient Services (Delivery)	See "Inpatient Services"	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services		
Inpatient Facility Services	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Inpatient Facility you will pay [0%- 50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Inpatient Doctor Services	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Outpatient Facility Services	[0%-50%] Coinsurance] [after Deductible] [no Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [0%- 50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
• Outpatient Doctor Services	[0%- 50%] Coinsurance] [No Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Partial Hospitalization Program / Intensive Outpatient Services	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendor Plans: Note: If you use a Preferred Partial Hospital/ Intensive Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Providers.]]		
• Office Visits	[Covered in PCP / SCP Copayment] [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” in the “Additional Federal Notices” section for details.		
Occupational Therapy	See “Therapy Services.”	
Office Visits		
• Primary Care Physician / Provider (PCP)	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[PC2: Note: If your PCP is part of our Enhanced Personal Health Care Program you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible].]		
• Specialty Care Physician / Provider (SCP)	[\$20- \$75] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Retail Health Clinic Visit [Preferred Vendors: Note: If you use a Preferred Retail Health Clinic you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Clinics.]]	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Online Visit [Preferred Vendors: Note: If you use a Preferred Online Visit Provider you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Providers.]]	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible]
Counseling- includes Family Planning and Nutritional Counseling (Other than Eating Disorders)	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Nutritional Counseling for Eating Disorders	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Allergy Testing	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Allergy Shots/Injections (other than allergy serum)	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic Lab (non-preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic X-ray (non-preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic Tests (non-preventive; including hearing and EKG)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Office Surgery	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Therapy Services:		
- Chiropractic Care & Spinal Manipulation	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Physical, Speech, & Occupational Therapy	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Dialysis / Hemodialysis	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Cardiac Rehabilitation & Pulmonary Therapy	[\$20- \$75] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (includes allergy serum)	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Optional if 3 visits apply: Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.]		
Orthotics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Outpatient Facility Services		
• Facility Surgery Charge	[0%-50%] Coinsurance] [after Deductible] [no Deductible]]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Doctor Surgery Charges	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Diagnostic Lab	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic X-ray	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible] for advanced diagnostic imaging services. [Please see anthem.com for a list of Preferred Facilities.]]		

Benefits	In-Network	Out-of-Network
- Therapy: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational Therapy - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Dialysis / Hemodialysis - Cardiac Rehabilitation & Pulmonary Therapy - See "Therapy Services" for details on Benefit Maximums. - Prescription Drugs Administered in an Outpatient Facility	- Chiropractic Care & Spinal Manipulation [\$10- \$50] Copayment [per visit] [0%-50%] Coinsurance [no Deductible] [after Deductible] - Physical, Speech, & Occupational Therapy [\$10- \$50] Copayment [per visit] [0%-50%] Coinsurance [no Deductible] [after Deductible] - Radiation / Chemotherapy / Non-Preventive Infusion & Injection [0%-50%] Coinsurance [no Deductible] [after Deductible] - Dialysis / Hemodialysis [0%-50%] Coinsurance [no Deductible] [after Deductible] - Cardiac Rehabilitation & Pulmonary Therapy [\$20- \$75] Copayment [per visit] [0%-50%] Coinsurance [no Deductible] [after Deductible]	- Chiropractic Care & Spinal Manipulation [30%-50%] Coinsurance after Deductible - Physical, Speech, & Occupational Therapy [30%-50%] Coinsurance after Deductible - Radiation / Chemotherapy / Non-Preventive Infusion & Injection [30%-50%] Coinsurance after Deductible - Dialysis / Hemodialysis [30%-50%] Coinsurance after Deductible - Cardiac Rehabilitation & Pulmonary Therapy [30%-50%] Coinsurance after Deductible - Prescription Drugs Administered in an Outpatient Facility [30%-50%] Coinsurance after Deductible
Physical Therapy	See "Therapy Services."	
Preventive Care	No Copayment, Deductible, or Coinsurance	[30%-50%] Coinsurance after Deductible
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	

Benefits	In-Network	Out-of-Network
Pulmonary Therapy	See “Therapy Services.”	
Radiation Therapy	See “Therapy Services.”	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See “Therapy Services.”	
Skilled Nursing Facility	See “Inpatient Services.”	
Speech Therapy	See “Therapy Services.”	
Surgery	Benefits are based on the setting in which Covered Services are received.	
[optional offer mandate – add when selected –Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime, In- and Out-of-Network combined]	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
- Physical Therapy - Occupational Therapy - Speech Therapy - Manipulation Therapy - Cardiac Rehabilitation	20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 36 visits per Benefit Period	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		

Benefits	In-Network	Out-of-Network
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	
Urgent Care Services (Office Visits)		
Urgent Care Office Visit Charge	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Testing	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Shots/ Injections (other than allergy serum)	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Office Surgery	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Vision Services for Members Through Age 18		
Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam Limited to one exam per Benefit Period	\$0 Copayment	Covered up to \$30
Standard Plastic Lenses Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Covered up to \$25
Bifocal	\$0 Copayment	Covered up to \$40
Trifocal	\$0 Copayment	Covered up to \$55
Progressive	\$0 Copayment	Covered up to \$40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost In-Network.		
Frames Limited to one set of frames from the Anthem Formulary per Benefit Period.	\$0 Copayment	Covered up to \$45
Contact Lenses Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye)	Benefits are based on the setting in which Covered Services are received.	
Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this <i>before</i> you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further details.) The requirements described below do not apply to the following: • Cornea and kidney transplants, which are covered as any other surgery; and • Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service. Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the “What’s Covered” section for additional details.		
Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
• Precertification required	During the Transplant Benefit Period, [no Copayment / Deductible / Coinsurance.] [0% - 50%] Coinsurance]	During the Transplant Benefit Period, You will pay [30% -50%] Coinsurance after Deductible. During the

Benefits	In-Network	Out-of-Network
	[after Deductible] Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
	[No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30%-50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.

Benefits	In-Network	Out-of-Network
Transportation and Lodging Transportation and Lodging Limit	[Standard: No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible] Covered, as approved by us, up to \$10,000 per transplant, In- and Out-of-Network combined.	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.] [Option: Not covered]
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure Donor Search Limit	[Standard: No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible] Covered, as approved by us, up to \$30,000 per transplant, In- and Out-of-Network combined.	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Live Donor Health Services Donor Health Service Limit	[Standard: No Copayment/ Deductible/ Coinsurance] [0% - 50%] Coinsurance after Deductible] Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. [Standard, but may remove for HSA plans that don't have copays: You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.] [Optional for Plans w/ Rx Deductible:		
Prescription Drug Deductible (Does not apply to Tier 1)		
[Per Member]	[\$250-\$500], In- and Out-of-Network combined]	
[Per Family]	[\$500- \$1,000], In- and Out-of-Network combined]	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)		30 days
Home Delivery (Mail Order) Pharmacy		90 days
Specialty Pharmacy (In-Network and Out-of-Network)		30 days*
	*See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
[Use for HSA Plans: Note: The Prescription Drug Copayments listed below will not apply until after the Plan Deductible is met.]		
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$10- \$15] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 2 Prescription Drugs	[\$30- \$50] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 3 Prescription Drugs	[\$60- \$90] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 4 Prescription Drugs	[0%-50%] Coinsurance [to a maximum of \$250- \$500] [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$25- \$38] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered
Tier 2 Prescription Drugs	[\$75- \$125] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered
Tier 3 Prescription Drugs	[\$150- \$225] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 4 Prescription Drugs	[0%-50%] Coinsurance] [to a maximum of [\$250-\$500] [after Deductible] per Prescription Drug	Not covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.		
[OPTIONAL-Brand Penalty: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.]		
[Regular PPO plans: Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]		
[HSA plans: Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]		
Orally Administered Cancer Chemotherapy	[Use with all regular plans: No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.	
	No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-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.]	
	[Use with HSA RX copay plans: After Deductible has been satisfied, no Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.	
	After Deductible has been satisfied, you get from an Out-of-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.]	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
[Use with HSA coinsurance plans: Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from an In-Network Pharmacy, Home Delivery Pharmacy, Specialty Pharmacy Network, or Non-Network Pharmacy.] 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.		

How Your Plan Works

Introduction

Your Plan is a PPO plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at [www.anthem.com], which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

[PC2 option:

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

Crediting Prior Plan Coverage

If you were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Group offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your Group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard® Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard®." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need health care, as long as you use a BlueCard® Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

In a non-Emergency situation, you can find the nearest contracted Provider by visiting the BlueCard® Doctor and Hospital Finder website [www.BCBS.com] or call the number on the back of your Identification Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard® program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard® Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your up to date Anthem Identification Card.

- In an Emergency, go straight to the nearest Hospital.
- The BlueCard® Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard® Worldwide.

Payment Details

- **Participating BlueCard® Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard® Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard® Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard® Worldwide Service Center. Then you can fill out a BlueCard® Worldwide claim form and send it with the original bill(s) to the BlueCard® Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard® Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard® Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard® Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review (“requesting Provider”). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by a BlueCard®/Out-of-Network/Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Request Categories

- **Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review-** A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an Inpatient admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
<i>Precertification Requests</i>	
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
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
<i>Predetermination Requests</i>	
Prospective Urgent	72 hours from the receipt of request
Prospective Non- Urgent	15 calendar days from the receipt of the request
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request

Continued Stay Review 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
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed.

For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for more important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See “Mental Health and Substance Abuse Services” later in this section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedure codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s)
- Occlusal
- Vertical- Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis)- Any combination of this procedure or periodontal maintenance (see “Periodontal Services” below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth)- Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention- per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy— Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy- If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments Limited to once per tooth per lifetime:

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal)- not including root canal therapy
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recent Fixed Prosthetic Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. [**Ortho / Dental Necessity option:** We will only cover Dentally Necessary orthodontic care. To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or

Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.]

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self-management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See “Therapy Services” later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.

- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

“Emergency” or “Emergency Medical Condition” means 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 layperson who possesses an average knowledge of health and medicine to: (a) place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

“Stabilize” means 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.

Emergency Care

“Emergency Care” means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, but you may have to pay the difference between the Out-of-Network Provider’s charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See “Getting Approval for Benefits” for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** has been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Optional: Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.]

[Optional: Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the “Preventive Care” benefit.]

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the “Home Care” benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor’s Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.

Urgent Care as described in “Urgent Care Services” later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,

- Diagnostic services,
- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the “Diagnostic Services” benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women’s contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”]
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per [Standard: pregnancy] [Benefit Period].
 - c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government’s web sites, <http://www.healthcare.gov/what-are-my-preventive-care-benefits>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/recs/acip/>.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" later in this booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members/All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Your Plan also covers certain oral surgeries for children. Please refer to “Dental Services for Members Through Age 18” for details.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services for Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In-Network.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglass lenses until the next Benefit Period. If you choose eyeglass lenses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

Benefits do not include glasses or contact lenses except as listed in the “Prosthetics” benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- **[Standard unless opt out allowed due to religious beliefs:** Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.

- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a Member age 18 or older. These products will be covered under the “Preventive Care” benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at [www.anthem.com].

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;

- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs. This tier contains higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the “Schedule of Benefits.” In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

[Standard for all plans except HSA: Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.]

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details.
- 2) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
- 3) **Administrative Charges**
 - a) Charges to complete claim forms,
 - b) Charges to get medical records or reports,
 - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - a. Acupuncture,
 - b. Holistic medicine,
 - c. Homeopathic medicine,
 - d. Hypnosis,
 - e. Aroma therapy,
 - f. Massage and massage therapy,
 - g. Reiki therapy,
 - h. Herbal, vitamin or dietary products or therapies,
 - i. Naturopathy,
 - j. Thermography,
 - k. Orthomolecular therapy,
 - l. Contact reflex analysis,
 - m. Bioenergetic synchronization technique (BEST),
 - n. Iridology-study of the iris,
 - o. Auditory integration therapy (AIT),
 - p. Colonic irrigation,
 - q. Magnetic innervation therapy,
 - r. Electromagnetic therapy.
- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

- 6) **Certain Providers** Service you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

15) Dental Services

- a) Dental care for Members age 19 or older.
- b) Dental services not listed as covered in this Booklet.
- c) Oral hygiene instructions.
- d) Case presentations.
- e) Athletic mouth guards, enamel microabrasion and odontoplasty.
- f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- h) Pulp vitality tests.
- i) Adjunctive diagnostic tests.
- j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.

- l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
 - m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
 - n) Incomplete root canals.
 - o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
 - p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - q) Provisional splinting, temporary procedures or interim stabilization.
 - r) Services of anesthesiologists, unless required by law.
 - s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
 - t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
 - u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
 - v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - w) Canal prep & fitting of preformed dowel & post.
 - x) Temporary, provisional or interim crown.
 - y) Occlusal procedures.
 - z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
 - aa) Pin retention is not covered when billed separately from restoration procedure.
 - bb) Services for the replacement of an existing partial denture with a bridge.
 - cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
 - dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
 - ee) Separate services billed when they are an inherent component of another covered service.
 - ff) Cone beam images.
 - gg) Anatomical crown exposure.
 - hh) Temporary anchorage devices.
 - ii) Sinus augmentation.
 - jj) Repair or replacement of lost/broken appliances.
- 16) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
- 17) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the criteria we use to determine if a Service is Experimental or Investigational is outlined below.

- 18) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 19) **Eye Exercises** Orthoptics and vision therapy.
- 20) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 21) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 22) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
 - a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 23) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.
- 24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers' Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- 27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- 29) **Infertility Treatment** Testing or treatment related to infertility.
- 30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

31) Medical Equipment and Supplies

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- c) Non-Medically Necessary enhancements to standard equipment and devices.

32) Medicare For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

33) Missed or Cancelled Appointments Charges for missed or cancelled appointments.

34) Non-Medically Necessary Services Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

35) Nutritional or Dietary Supplements Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

36) Oral Surgery Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

37) Personal Care and Convenience

- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
- b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
- c) Home workout or therapy equipment, including treadmills and home gyms,
- d) Pools, whirlpools, spas, or hydrotherapy equipment.
- e) Hypo-allergenic pillows, mattresses, or waterbeds,
- f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

38) Private Duty Nursing 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 Care Services benefit as specifically stated in the "What's Covered" section.

39) Prosthetics Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

40) Sex Change Services and supplies for a sex change and/or the reversal of a sex change.

41) Sexual Dysfunction Services or supplies for male or female sexual problems.

42) Smoking Cessation Programs Programs to help you stop smoking if the program is not affiliated with Anthem.

43) Stand-By Charges Stand-by charges of a Doctor or other Provider.

44) [Religious group opt out to exclude: Sterilization] For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]

45) Surrogate Mother Services Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

- 46) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 47) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 48) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 49) **Vision Services**
- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
 - b) Safety glasses and accompanying frames.
 - c) For two pairs of glasses in lieu of bifocals.
 - d) Plano lenses (lenses that have no refractive power).
 - e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
 - f) Vision services not listed as covered in this Booklet.
 - g) Cosmetic lenses or options.
 - h) Blended lenses.
 - i) Oversize lenses.
 - j) Sunglasses and accompanying frames.
 - k) For services or supplies combined with any other offer, coupon or in-store advertisement.
 - l) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
 - m) Certain frames in which the manufacturer imposes a no discount policy.
- 50) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover Bariatric Surgery per mandate option: This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

- 51) **[Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery]** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.]

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. **[Optional non-standard: Clinically-Equivalent Alternatives]** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your Doctor believes you need to keep using a certain Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.]

3. **Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.

[Religious group opt out to exclude Contraceptive drugs:

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "**Prescription Drugs Administered by a Medical Provider**" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments. While these services are not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they may be covered under the "Dental Services for Members Through Age 18" benefit. Please see that section for further details.
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.

15. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these may be covered under the “Allergy Services” benefit. Please see that section for details.
16. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
18. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one or more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Programs" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total out of pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*

- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.
- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of \$1500, or \$450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is \$500, you may receive a bill from the Out-of-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your In-Network Copayment of \$25, your total out of pocket expense would be \$325.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem's Service Area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare Providers. Anthem's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside Anthem's Service Area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When covered healthcare services are provided outside of our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. An Out-of-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 [(carve-out) Medicare,] 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 generally 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.

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.

“Recovery” means is money you receive from another, their insurer or from any “Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.

- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to [anthem.com](https://www.anthem.com) and select Customer Support > Contact Us. Or call the Member Services number on your ID card

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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.

We will also accept Grievances filed in writing, including by facsimile or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-800-368-3238] if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 five (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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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.

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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the 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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- **[Domestic partner coverage:** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who **[Standard only when affidavit used:** has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard only when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstance:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- Subscriber and child(ren);
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during [**Standard:** an Open Enrollment period or during] a Special Enrollment period, as described below.

[Standard / Open Enrollment: Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [**Standard:** prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying Us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Dependents:</u> A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave. Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled.

You should enroll in Medicare Part B as soon as possible to avoid potential liability.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against [Anthem] based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/ Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits ” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the “Schedule of Benefits ” for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in “Benefits After Termination.”

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the “What's Covered” section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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 "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

[Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.]

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the “What's Covered” section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does **not** include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the “Schedule of Benefits” for details.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Predetermination

Please see the section “Getting Approval for Benefits ” for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 2) Insulin, diabetic supplies, and syringes.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the “What’s Covered” section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

Anthem [Gold][Silver][Bronze] Blue Preferred [on exchange only: X] HMO
[Insert INN Cost Share: Copay or Deductible / Coinsurance / OOP
Limit] [Plus] [w/HSA]



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

[on-exchange only: If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.]

Anthem Insurance Companies, Inc.

**[120 Monument Circle]
[Indianapolis, Indiana 46204]**

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, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, [www.anthem.com]

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:]

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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/doi

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

[Use with HSAs:

High-Deductible Health Plan for Use with Health Savings Accounts

This Plan is meant to be federally tax qualified and used with a qualified health savings account. Approval by the **Indiana Department of Insurance** does not guarantee tax qualification and this Plan has not been submitted for approval by the IRS. Please seek the advice of a tax advisor.]

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.



[

President

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, Urgent Care, or Authorized Services. Please be sure to contact us if you are not sure if we have approved an Authorized Service. Benefits are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an approved Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for additional details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year][off-exchange only: Plan Year]
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Deductible	In-Network
[Per Member]	[\$1,250-6,000]
[Per Family [Delete for non-embedded HSA plans – All other Members combined]]	[\$2,500-12,000]
[Option for Non-Embedded HSA Plans: If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amount applies to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amount applies.)] When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.	

Coinsurance	In-Network
Plan Pays	[90%-70%]
Member Pays	[10%-30%]
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an approved Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.	

Out-of-Pocket Limit	In-Network
[Per Member]	[\$4,500-6,600]
[Per Family [Delete for Non-Embedded HSA Plans – All other Members combined]]	[\$9,000-\$13,200]
[Option for Non-Embedded HSA Plans: If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amount applies to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amount applies.)] The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or charges for non-Covered Services. Once the Out-of- Pocket Limit is satisfied, you will not have to pay additional [Deductibles or Coinsurance][Deductibles, Coinsurance, or Copayments] for the rest of the Benefit Period, except for the services listed above.	

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Ambulance Services (Air and Water)	[10%-30%] Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Ambulance Services (Ground)	[10%-30%] Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	Not Covered
Behavioral Health Services	See "Mental Health and Substance Abuse Services."	Not covered
Cardiac Rehabilitation	See "Therapy Services."	Not covered
Chemotherapy	See "Therapy Services."	Not covered

Benefits	In-Network	Out-of-Network
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	Not covered
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	Not covered
Dental Services Accidental Injury Benefit Maximum	\$3,000 per Accidental Injury	Not covered
Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that we are required to cover by law.		
Dental Services For Members Through Age 18 Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• Diagnostic and Preventive Services	10% Coinsurance after Deductible	Not covered
• Basic Restorative Services	40% Coinsurance after Deductible	Not covered
• Endodontic Services	50% Coinsurance after Deductible	Not covered
• Periodontal Services	50% Coinsurance after Deductible	Not covered
• Oral Surgery Services	50% Coinsurance after Deductible	Not covered
• Major Restorative Services	50% Coinsurance after Deductible	Not covered
• Prosthodontic Services	50% Coinsurance after Deductible	Not covered
• Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	Not covered
Dentally Necessary Orthodontic Care Waiting Period	12 months	Not covered

Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	Not covered
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	Not covered
[Optional/not for HSAs - Note: If you use a Preferred Diagnostic Lab (i.e., reference labs), you may not have to pay a Copayment, Deductible, or Coinsurance. Please see anthem.com for a list of these labs.]		
Dialysis	See "Therapy Services."	Not covered
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	[10%-30%] Coinsurance after Deductible	Not covered
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period	Not covered
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.		
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [Copayment waived if admitted]	
Emergency Room Doctor Charge	[10%-30%] Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
- Other Facility Charges (including diagnostic x-ray and lab services, medical supplies) - Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible	
Home Care		
• Home Care Visits	[10%-30%] Coinsurance after Deductible	Not covered
• Home Dialysis	[10%-30%] Coinsurance after Deductible	Not covered
• Home Infusion Therapy	[10%-30%] Coinsurance after Deductible	Not covered
• Specialty Prescription Drugs	[10%-30%] Coinsurance after Deductible	Not covered
• Other Home Care Services / Supplies	[10%-30%] Coinsurance after Deductible	Not covered
Home Care Benefit Maximum	100 visits per Benefit Period The limit does not apply to Home Infusion Therapy or Home Dialysis.	Not covered
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period 164 visits per Lifetime	Not covered
Home Infusion Therapy		
	See "Home Care."	Not covered
Hospice Care		
- Home Care - Respite Hospital Stays	0% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	Not covered
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Skilled Nursing Facility	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period	Not covered
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	[10%-30%] Coinsurance after Deductible	Not covered
[For plans with hospital copay: Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.] [For plans with hospital copay: Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.]		
Doctor Services for:		
General Medical Care / Evaluation and Management (E&M)	[10%-30%] Coinsurance after Deductible	Not covered
Surgery	[10%-30%] Coinsurance after Deductible	Not covered
Maternity and Reproductive Health Services		

Benefits	In-Network	Out-of-Network
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.	[10%-30%] Coinsurance after Deductible [Use only when office visit copay applies: The Office Visit Copayment will also apply to the first prenatal visit.]	Not covered
Inpatient Services (Delivery)	See "Inpatient Services"	Not covered
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services		
Inpatient Facility Services	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Residential Treatment Center Services	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible]	Not Covered
Inpatient Doctor Services	[10%-30%] Coinsurance after Deductible	Not covered
Outpatient Facility Services	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
Outpatient Doctor Services	[10%-30%] Coinsurance after Deductible	Not covered
Partial Hospitalization Program / Intensive Outpatient Services	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
Office Visits	[[\$30-35] Copayment per visit for the first [3] visits, then] [10%-30%] Coinsurance after Deductible	Not covered
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.		
Occupational Therapy	See "Therapy Services."	Not covered

Benefits	In-Network	Out-of-Network
Office Visits		
• Primary Care Physician / Provider (PCP)	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Specialty Care Physician / Provider (SCP)	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Retail Health Clinic Visit	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Online Visit	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Counseling - Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	[10%-30%] Coinsurance after Deductible	Not covered
• Nutritional Counseling for Eating Disorders	[10%-30%] Coinsurance after Deductible	Not covered
• Allergy Testing	[10%-30%] Coinsurance after Deductible	Not covered
• Allergy Shots / Injections (other than allergy serum)	[10%-30%] Coinsurance after Deductible	Not covered
• Preferred Diagnostic Labs (i.e., reference labs)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Lab (non-preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic X-ray (non-preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Tests (non-preventive; including hearing and EKG)	[10%-30%] Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible	Not covered
• Office Surgery	[10%-30%] Coinsurance after Deductible	Not covered
• Therapy Services:		Not covered
- Chiropractic Care & Spinal Manipulation	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
- Physical, Speech, & Occupational Therapy - Dialysis / Hemodialysis - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Cardiac Rehabilitation & Pulmonary Therapy See "Therapy Services" for details on Benefit Maximums.	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered Not covered Not covered Not covered
• Prescription Drugs Administered in the Office (includes allergy serum)	[10%-30%] Coinsurance after Deductible	Not covered
[Not for use with coinsurance only plans or HSA plans: Important Note on Office Visit Copayments: Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.]		
Orthotics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	Not covered
Outpatient Facility Services		
• Facility Surgery Charge • Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies) • Doctor Surgery Charges • Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible	Not covered Not covered Not covered Not covered

Benefits	In-Network	Out-of-Network
- Other Facility Charges (for procedure rooms or other ancillary services) - Diagnostic Lab - Diagnostic X-ray - Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive) - Advanced Diagnostic Imaging (including MRIs, CAT scans) - Therapy: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Dialysis / Hemodialysis - Cardiac Rehabilitation & Pulmonary Therapy - Prescription Drugs Administered in an Outpatient Facility See "Therapy Services" for details on Benefit Maximums.	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible [10%-30%] Coinsurance after Deductible	- Not covered - Not covered - Not covered - Not covered - Not covered - Not covered - Not covered - Not covered - Not covered - Not covered
Physical Therapy	See "Therapy Services."	Not covered
Preventive Care	No Copayment, Deductible, or Coinsurance	Not covered

Benefits	In-Network	Out-of-Network
Prosthetics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	Not covered
Pulmonary Therapy	See “Therapy Services.”	Not covered
Radiation Therapy	See “Therapy Services.”	Not covered
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Respiratory Therapy	See “Therapy Services.”	Not covered
Skilled Nursing Facility	See “Inpatient Services.”	Not covered
Speech Therapy	See “Therapy Services.”	Not covered
Surgery	Benefits are based on the setting in which Covered Services are received.	Not covered
• [<i>optional offer mandate – add when selected</i> Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime]	Not covered
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	Not covered
Therapy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Benefit Maximum(s):	Benefit Maximum(s) are for office and outpatient visits combined.	Not covered
• Physical Therapy	20 visits per Benefit Period	Not covered

Benefits	In-Network	Out-of-Network
Occupational Therapy	20 visits per Benefit Period	Not covered
Speech Therapy	20 visits per Benefit Period	Not covered
Manipulation Therapy	20 visits per Benefit Period	Not covered
Cardiac Rehabilitation	36 visits per Benefit Period	Not covered
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	Not covered
Urgent Care Services (Office Visit) - Urgent Care Office Visit Charge [10%-30%] Coinsurance after Deductible - Allergy Testing [10%-30%] Coinsurance after Deductible - Allergy Shots / Injections (other than allergy serum) [10%-30%] Coinsurance after Deductible - Preferred Diagnostic Labs (i.e., reference labs) [10%-30%] Coinsurance after Deductible - Other Charges (e.g., diagnostic x-ray and lab services, medical supplies) [10%-30%] Coinsurance after Deductible - Advanced Diagnostic Imaging (including MRIs, CAT scans) [10%-30%] Coinsurance after Deductible - Office Surgery [10%-30%] Coinsurance after Deductible - Prescription Drugs Administered in the Office (includes allergy serum) [10%-30%] Coinsurance after Deductible		

Benefits	In-Network	Out-of-Network
If you see an Out-of-Network Provider, that Provider may also bill you for any charges over the Plan's Maximum Allowed Amount.		
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		

Vision Services For Members Through Age 18

Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.

- | | | |
|---------------------------|---------------|-------------|
| • Routine Eye Exam | \$0 Copayment | Not covered |
|---------------------------|---------------|-------------|

Limited to one exam per Benefit Period

• **Standard Plastic Lenses**

Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.

Single Vision	\$0 Copayment	Not covered
Bifocal	\$0 Copayment	Not covered
Trifocal	\$0 Copayment	Not covered
Progressive	\$0 Copayment	Not covered

Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.

- | | | |
|-----------------|---------------|-------------|
| • Frames | \$0 Copayment | Not covered |
|-----------------|---------------|-------------|

Limited to one set of frames from the Anthem Formulary per Benefit Period.

• **Contact Lenses**

Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.

Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Not covered
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Not covered
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye)		
Benefits are based on the setting in which Covered Services are received.		Not covered
Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further information.)

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Transplant Benefit Period

In-Network Transplant Provider

Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call

Out-of-Network Transplant Provider

Not covered

	the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	
	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, [Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
Precertification required	Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits or Office Visits depending where the service is performed.	
	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
Covered Transplant Procedure during the Transplant Benefit Period	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
Transportation and Lodging	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
Transportation and Lodging Limit	Covered, as approved by us, up to [\$10,000] per transplant	Not covered
Unrelated donor searches from an authorized,	[Standard: No Copayment	Not covered

licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure		/ Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	
• Donor Search Limit		Covered, as approved by us, up to [\$30,000] per transplant.	Not covered
Live Donor Health Services		[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
• Donor Health Service Limit		Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits

Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.

[Option: Prescription Drug Deductible (waived for Tier 1)

Per Member [\$250, 750]

Per Family [\$500, 1,500]]

Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.]

Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits

Retail Pharmacy	30 days
Home Delivery (Mail Order) Pharmacy	90 days
Specialty Pharmacy	30 days*

*See additional information in the "Specialty Drug Copayments / Coinsurance" section below.

	In-Network	Out-of-Network
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$15 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 2 Prescription Drugs	[\$35, 50 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 3 Prescription Drugs	[\$70, 90 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 4 Prescription Drugs	[10%, 30% Coinsurance] [to a maximum of \$500] per Prescription Drug [after Deductible]	Not covered

Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$38 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 2 Prescription Drugs	[\$88, 125 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 3 Prescription Drugs	[\$175, 225 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 4 Prescription Drugs	[10%, 30% Coinsurance] [to a	Not covered

maximum of \$500] per Prescription Drug [after Deductible]	
Specialty Drug Copayments / Coinsurance:	
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy. [Optional: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.] [Standard: Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.] [HSA plans Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]	
Orally Administered Cancer Chemotherapy	[Use with all regular plans - No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.] [Use with HSA coinsurance plans - Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.] 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.

How Your Plan Works

Introduction

Your Plan is a HMO plan. To get benefits for Covered Services, you must use In-Network Providers, unless we have approved an Authorized Service or if your care involves an Emergency or Urgent Care situation.

In-Network Provider Services

When you get care from an In-Network Provider or as part of an Authorized Service, benefits are available for Covered Services. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

Primary Care Physicians / Providers (PCP)

PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, and geriatricians. Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

If, when you first enroll (sign up) for coverage under this Plan, you are under the care of an Out-of-Network Provider, you should tell us right away. To keep getting care under this Plan from any Out-of-Network Provider, we must approve an Authorized Service with that Provider or the services will be denied.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any In-Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call us at the telephone number listed on the back of your Identification Card.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

[off exchange only: Guest Memberships]

When you or any of your covered dependents will be staying temporarily outside of the Service Area for more than 90 days, you can request a guest membership to a Blue Cross and Blue Shield affiliated health maintenance organization in that area. An example of when this service may be utilized is when a Dependent student attends a school outside of the service area. Call Customer Services at the number on the back of your ID card to make sure that the area in which you or your Dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated health maintenance organization plans. If the area is within the network, you will need to complete a guest membership application and you will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield health maintenance organization affiliate where you or your covered Dependents will be staying. A Customer Services representative will explain any limitations or restrictions to this benefit. If you are staying in an area that is not within the Guest Membership Network, this service will not be available.]

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Service Area

The Service Area for this Plan is the State of Indiana.

[PC2 option:

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in our Service Area. If you are receiving care from an In-Network Provider whose contractual relationship with us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated In-Network Provider for a set period.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

[off-exchange only - Crediting Prior Plan Coverage

If You were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then You will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If Your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and You were covered by the other product immediately before enrolling in this product with no break in coverage, then You may get credit for any accrued Deductible and Out-of-Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If Your Group offers more than one of our products, and You change from one product to another with no break in coverage, You will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If Your Group offers coverage through other products or carriers in addition to ours, and You change products or carriers to enroll in this product with no break in coverage, You will get credit for any accrued Deductible, Out-of-Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or

- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.]

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need Emergency or urgent care services as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details. Please note that you only have coverage for Emergency and urgent care health care services when traveling outside the United States.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.

- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review (“requesting Provider”). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by an Out-of-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for an Out-of-Network Provider unless: - You get authorization to use an Out-of-Network Provider before the service is given; or - For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Request Categories

- **Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review-** A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an inpatient admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
<i>Precertification Requests</i>	
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
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
<i>Predetermination Requests</i>	
Prospective Urgent	72 hours from the receipt of request
Prospective Non- Urgent	15 calendar days from the receipt of the request
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services**Endodontic Therapy on Primary Teeth**

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;

- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18..

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;

- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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: (a)

place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means 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.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will not be covered unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

See “Therapy Services” later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,

- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.]

[Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the “Preventive Care” benefit.]

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),

- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the “Home Care” benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor’s Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.

Urgent Care as described in “Urgent Care Services” later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the “Diagnostic Services” benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women’s contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”]
 - b. Breastfeeding support, supplies, and counseling. [Standard Benefits for breast pumps are limited to [1-10 one] pump per [Standard pregnancy] [Benefit Period].]
 - c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites, [<http://www.healthcare.gov/center/regulations/prevention.html>.] [<http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.]

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” later in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:]

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members/All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.

- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services For Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In Network.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

Benefits do not include glasses or contact lenses except as listed in the “Prosthetics” benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- [Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at [www.anthem.com].]

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth,

shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the “Schedule of Benefits.” In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

[Standard for all plans except HSA:

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.]

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details. .
- 2) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
- 3) **Administrative Charges**
 - a) Charges to complete claim forms,
 - b) Charges to get medical records or reports,
 - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - a. Acupuncture,
 - b. Holistic medicine,
 - c. Homeopathic medicine,
 - d. Hypnosis,
 - e. Aroma therapy,
 - f. Massage and massage therapy,
 - g. Reiki therapy,
 - h. Herbal, vitamin or dietary products or therapies,
 - i. Naturopathy,
 - j. Thermography,
 - k. Orthomolecular therapy,
 - l. Contact reflex analysis,
 - m. Bioenergetic synchronization technique (BEST),
 - n. Iridology-study of the iris,
 - o. Auditory integration therapy (AIT),
 - p. Colonic irrigation,
 - q. Magnetic innervation therapy,
 - r. Electromagnetic therapy.

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence..
- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

15) Dental Services

- a) Dental care for Members age 19 or older.
- b) Dental services not listed as covered in this Booklet.
- c) Oral hygiene instructions.
- d) Case presentations.
- e) Athletic mouth guards, enamel microabrasion and odontoplasty.
- f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- h) Pulp vitality tests.
- i) Adjunctive diagnostic tests.
- j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.

- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
 - l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
 - m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
 - n) Incomplete root canals.
 - o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
 - p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - q) Provisional splinting, temporary procedures or interim stabilization.
 - r) Services of anesthesiologists, unless required by law.
 - s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
 - t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
 - u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
 - v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - w) Canal prep & fitting of preformed dowel & post.
 - x) Temporary, provisional or interim crown.
 - y) Occlusal procedures.
 - z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
 - aa) Pin retention is not covered when billed separately from restoration procedure.
 - bb) Services for the replacement of an existing partial denture with a bridge.
 - cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
 - dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
 - ee) Separate services billed when they are an inherent component of another covered service.
 - ff) Cone beam images.
 - gg) Anatomical crown exposure.
 - hh) Temporary anchorage devices.
 - ii) Sinus augmentation.
 - jj) Repair or replacement of lost/broken appliances.
- 16) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
- 17) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services,

whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the process and criteria we use to determine if a Service is Experimental or Investigational are outlined below.

- 18) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 19) **Eye Exercises** Orthoptics and vision therapy.
- 20) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 21) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 22) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
 - a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 23) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.
- 24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- 27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- 29) **Infertility Treatment** Testing or treatment related to infertility.
- 30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 31) **Medical Equipment and Supplies**

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
- 32) **Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- 33) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 34) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 35) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 36) **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Urgent Care, or Authorized Services.
- 37) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 38) **Personal Care and Convenience**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c) Home workout or therapy equipment, including treadmills and home gyms,
 - d) Pools, whirlpools, spas, or hydrotherapy equipment.
 - e) Hypo-allergenic pillows, mattresses, or waterbeds,
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- 39) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.
- 40) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.
- 41) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.
- 42) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 43) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.
- 44) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 45) **[Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]

- 46) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- 47) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 48) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 49) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 50) **Vision Services**
- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
 - b) Safety glasses and accompanying frames.
 - c) For two pairs of glasses in lieu of bifocals.
 - d) Plano lenses (lenses that have no refractive power)
 - e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
 - f) Vision services not listed as covered in this Booklet.
 - g) Cosmetic lenses or options.
 - h) Blended lenses.
 - i) Oversize lenses.
 - j) Sunglasses and accompanying frames.
 - k) For services or supplies combined with any other offer, coupon or in-store advertisement.
 - l) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
 - m) Certain frames in which the manufacturer imposes a no discount policy.
- 51) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
- This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- [Add if group chooses to cover Bariatric Surgery per mandate option** This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]
- 52) **Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgeries that reduce stomach size), or gastric banding procedures].

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

[Optional:

2. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your Physician believe you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE. We will cover your current Prescription Drug only if We agree that it is Medically Necessary and appropriate over its clinically equivalent alternative.]

3. **Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.

[Religious opt out to exclude Contraceptive Drugs:

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary).** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Physician believe you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments.
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.

15. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
16. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
18. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan. Details on the process and criteria your Plan uses to decide if a service is Experimental or Investigational are outlined below.

If you disagree with our denial of a service as Experimental or Investigational, you have the right to file a Grievance with us. Please refer the **Grievance and External Review Procedures** section of this Booklet for more information.

Process to Determine an Experimental or Investigational Service

Our process to decide whether a service is Experimental or Investigational includes medical and technical research of the service, committee review and decision, and final approval by our Chief Medical Officer.

First, our medical policy staff reviews a service based on the criteria listed in the provision below. Information on the service is gathered and combined by our Medical policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of our formal policy.

Next, the draft of the policy and literature on the service is distributed to the medical policy committee for review and discussion. The committee, which meets four times a year, is made up of a panel of Plan Physicians, most of which are actively practicing In-Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory organizations. The committee may also ask for input from one or more Physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the service, the committee recommends a final policy. The policy is forwarded to the medical policy committee chairman and Chief Medical Officer for approval.

Our policy on a service is reviewed as appropriate, every three years or less, by our medical policy staff and medical policy committee, with approval of our Chief Medical Officer and medical policy committee chairman.

We also maintain a process for deciding when existing policy on a service calls for added review and change and alerts our medical policy committee of the need to change the existing policy or make a new policy. This may come about as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change our position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by us to make policy change between regularly scheduled meetings of the medical policy committee.

Criteria to Determine an Experimental or Investigational Service

The criteria we or our designee use when making the determination of whether a Service is Experimental or Investigational when it is rendered for the evaluation or treatment of a disease, injury, illness or condition is outlined below. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Programs" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under this product are not covered except for Emergency Care, or when allowed as an Authorized Service by us. When you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency Care, or unless the services are approved by us as an Authorized Service.

For Covered Services You receive from an Out-of-Network Provider for Emergency Care or for services approved as an Authorized Service, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the

Provider will render. You will also need to know the Provider's charges to calculate your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

If you receive Covered Services in an In-Network Provider facility from an Out-of-Network Provider, such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with the In-Network Hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Care or Urgent Care services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a

Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("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.

Typically, when accessing care outside Anthem's Service Area and the Service Area of Anthem's corporate parent, 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 non-participating healthcare Providers. Anthem's payment practices in both instances are described below.

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care and urgent care obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your Primary Care Physician ("PCP").

BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area 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.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount, as stated in your Booklet.

Emergency Care Services: If you experience a Medical Emergency while traveling outside the Anthem Service Area, go to the nearest Emergency or Urgent Care Facility.

Whenever you access covered healthcare services outside Anthem's and, if applicable, Anthem's corporate parent's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special

arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. A Out-of-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 [(*carve-out*) Medicare,] 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 generally 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.

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.

“Recovery” means is money you receive from another, their insurer or from any “Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.

- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-800-368-3238] if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3 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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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.

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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and:
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- **[Domestic partner coverage: [This only applies to Groups who have this option:]]** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who **[Standard when affidavit used]** has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for [12 months] or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll [during an Open Enrollment period or] during a Special Enrollment period, as described below.

[Open Enrollment]

Open Enrollment refers to a period of time, usually [60 days], during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Dependents:</u> A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits

Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

If we terminate the Group Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, we will continue your coverage for Inpatient Covered Services. Coverage will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after the Group Contract terminated;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by us;
- The Premium is not paid within the grace period shown in the Group Contract.

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Corporate Structure

The Plan is an Indiana domiciled insurance corporation owned by its stockholders and directed by a board of directors, who provide general leadership to the Plan. It is managed by a team of officers who receive direction from the board of directors and in turn direct the operations of the Plan. The Plan consists of a number of operational divisions including, but not limited to: Operations, Medical Management, Network Development, Marketing, Claims Administration, Risk Management, Legal and Member Services.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing

eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health

assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the “Schedule of Benefits” for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in “Benefits After Termination.”

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the “What’s Covered” section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Medical technology or a new application of existing medical technology, including medical procedures, Drugs, and devices for treating a medical condition, illness, or diagnosis that:

- is not generally accepted by informed health care professionals in the United States as effective; or

- has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

For how this is determined, see the “What’s Not Covered” section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient’s Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the “What’s Covered” section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Claims Payment” section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

[Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.]

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the

formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Predetermination

Please see the section “Getting Approval for Benefits ” for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 2) Insulin, diabetic supplies, and syringes.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

**Anthem Bronze Blue Preferred [on exchange only: X] POS 6000/30%/6600
Plus**



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

[on-exchange only: If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.]

Anthem Insurance Companies, Inc.

**[120 Monument Circle]
[Indianapolis, Indiana 46204]**

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, [www.anthem.com]. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, [www.anthem.com]

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:]

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a

federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

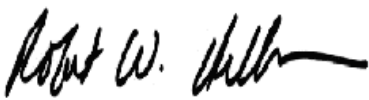

[President]

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] [off-exchange only: Plan Year]
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Deductible	In-Network	Out-of-Network
Per Member	\$6,000	\$12,000
Per Family - All other Members combined	\$12,000	\$24,000
The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.		

Coinsurance	In-Network	Out-of-Network
Plan Pays	70%	50%
Member Pays	30%	50%
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	\$6,600	\$13,200
Per Family – All other Members combined	\$13,200	\$26,400
The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services. The Out-of-Pocket Limit does not include amounts you pay for following benefits: • Out-of-Network Human Organ and Tissue Transplant services. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water)	30% Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see “Getting Approval for Benefits” for details.		
Ambulance Services (Ground)	30% Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see “Getting Approval for Benefits” for details.		
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	See “Mental Health and Substance Abuse Services.”	
Cardiac Rehabilitation	See “Therapy Services.”	
Chemotherapy	See “Therapy Services.”	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	
Dental Services Accidental Injury Benefit Maximum	\$3,000 per Accidental Injury In- and Out-of-Network combined	
Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that we are required to cover by law.		
Dental Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
Diagnostic and Preventive Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Basic Restorative Services	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dentally Necessary Orthodontic Care Waiting Period	12 Months	
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under “Preventive Care.”	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Dialysis	See “Therapy Services.”	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period In- and Out-of-Network combined	
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		
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, and Copayment as any other service under this Plan.		
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	\$250 Copayment per visit plus 30% Coinsurance after Deductible	
	Copayment waived if admitted	
Emergency Room Doctor Charge	30% Coinsurance after Deductible	
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	
Home Care		
Home Care Visits	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Dialysis	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Infusion Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Specialty Prescription Drugs	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Home Care Services / Supplies	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period In- and Out-of-Network combined	
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period In- and Out-of-Network combined	
	164 visits per Lifetime In- and Out-of-Network combined	
Home Infusion Therapy	See “Home Care.”	
Hospice Care		
- Home Care - Respite Hospital Stays	0% Coinsurance after Deductible	50% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility. Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission. Doctor Services for: - General Medical Care / Evaluation and Management (E&M) 30% Coinsurance after Deductible 50% Coinsurance after Deductible - Surgery 30% Coinsurance after Deductible 50% Coinsurance after Deductible		
Maternity and Reproductive Health Services - Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) 30% Coinsurance after Deductible 50% Coinsurance after Deductible If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately. - Inpatient Services (Delivery) See "Inpatient Services" Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services - Inpatient Facility Services \$500 Copayment per admission plus 30% Coinsurance after Deductible 50% Coinsurance after Deductible - Residential Treatment Center Services \$500 Copayment per admission plus 30% Coinsurance after Deductible 50% Coinsurance after Deductible - Inpatient Doctor Services 30% Coinsurance after Deductible 50% Coinsurance after Deductible - Outpatient Facility Services \$250 Copayment per visit plus 30% Coinsurance after Deductible 50% Coinsurance after Deductible		

Benefits	In-Network	Out-of-Network
Outpatient Doctor Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Office Visits	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” in the “Additional Federal Notices” section for details.		
Occupational Therapy	See “Therapy Services.”	
Office Visits		
Primary Care Physician / Provider (PCP)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Specialty Care Physician / Provider (SCP)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Retail Health Clinic Visit	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Online Visit	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Nutritional Counseling for Eating Disorders - Allergy Testing - Allergy Shots / Injections (other than allergy serum) - Preferred Diagnostic Labs (i.e., reference labs) - Diagnostic Lab (non-preventive) - Diagnostic X-ray (non-preventive) - Diagnostic Tests (non-preventive; including hearing and EKG) - Advanced Diagnostic Imaging (including MRIs, CAT scans) - Office Surgery - Therapy Services: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational Therapy - Dialysis / Hemodialysis - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Cardiac Rehabilitation & Pulmonary Therapy	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible \$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible \$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible \$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		

Benefits	In-Network	Out-of-Network
Prescription Drugs Administered in the Office (includes allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.		
Orthotics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	
Outpatient Facility Services		
Facility Surgery Charge	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Doctor Surgery Charges	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Lab	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic X-ray	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Therapy: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Dialysis / Hemodialysis - Cardiac Rehabilitation & Pulmonary Therapy See "Therapy Services" for details on Benefit Maximums. - Prescription Drugs Administered in an Outpatient Facility	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible
Physical Therapy	See "Therapy Services."	
Preventive Care	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Pulmonary Therapy	See "Therapy Services."	
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See "Therapy Services."	

Benefits	In-Network	Out-of-Network
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	See "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received.	
• [<i>optional offer mandate – add when selected</i> –Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime In- and Out-of-Network combined]	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services Benefit Maximum(s): • Physical Therapy • Occupational Therapy • Speech Therapy • Manipulation Therapy • Cardiac Rehabilitation Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit. Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.	Benefits are based on the setting in which Covered Services are received. Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined. 20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 20 visits per Benefit Period 36 visits per Benefit Period	
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	

Benefits	In-Network	Out-of-Network
Urgent Care Services (Office Visits)		
• Urgent Care Office Visit Charge	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Testing	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (other than allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (includes allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Vision Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
• Routine Eye Exam	\$0 Copayment	Covered up to \$30
Limited to one exam per Benefit Period		
• Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Covered up to \$25

Benefits	In-Network	Out-of-Network
Bifocal	\$0 Copayment	Covered up to \$40
Trifocal	\$0 Copayment	Covered up to \$55
Progressive	\$0 Copayment	Covered up to \$40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.		
Frames	\$0 Copayment	Covered up to \$45
Limited to one set of frames from the Anthem Formulary per Benefit Period.		
Contact Lenses		
Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		
Benefits are based on the setting in which Covered Services are received.		

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further details.)

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services, related to a Covered Transplant Procedure, that you get before or after the

Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of- Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
Precertification required	During the Transplant Benefit Period, no Copayment / Deductible / Coinsurance. Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	During the Transplant Benefit Period, You will pay 50% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for

		Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers No Copayment / Deductible / Coinsurance	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers 50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant In- and Out-of-Network combined	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant In- and Out-of-Network combined	

Live Donor Health Services	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Prescription Drug Deductible (waived for Tier 1)		
Per Member	\$250 In- and Out-of-Network combined	
Per Family	\$500 In- and Out-of-Network combined	
Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy (In-Network and Out-of-Network)	30 days*	
	*See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$15 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 2 Prescription Drugs	\$35 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 3 Prescription Drugs	\$70 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 4 Prescription Drugs	\$30% Coinsurance to a maximum of \$500 per Prescription Drug	50% Coinsurance per Prescription Drug
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$38 Copayment per Prescription Drug	Not Covered
Tier 2 Prescription Drugs	\$88 Copayment per Prescription Drug	Not Covered
Tier 3 Prescription Drugs	\$175 Copayment per Prescription Drug	Not Covered
Tier 4 Prescription Drugs	\$30% Coinsurance to a maximum of \$500 per Prescription Drug	Not Covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy. [Optional: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.]		

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.		
Orally Administered Cancer Chemotherapy	No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In--Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.	
	No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-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.	

How Your Plan Works

Introduction

Your Plan is a Point of Service (POS) plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

Service Area

The Service Area for this Plan is the State of Indiana.

[PC2 option:

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in our Service Area. If you are receiving care from an In-Network Provider whose contractual relationship with us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated In-Network Provider for a set period.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

[off exchange only: Crediting Prior Plan Coverage

If You were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then You will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If Your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and You were covered by the other product immediately before enrolling in this product with no break in coverage, then You may get credit for any accrued Deductible and Out-of-Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If Your Group offers more than one of our products, and You change from one product to another with no break in coverage, You will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If Your Group offers coverage through other products or carriers in addition to ours, and You change products or carriers to enroll in this product with no break in coverage, You will get credit for any accrued Deductible, Out-of-Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.]

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need Emergency or urgent care services, as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details. Please note that you only have coverage for Emergency and urgent care health care services when traveling outside the United States.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review (“requesting Provider”). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by a BlueCard/Out-of-Network/Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Request Categories

- **Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review-** A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an Inpatient admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
<i>Precertification Requests</i>	
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
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
<i>Predetermination Requests</i>	
Prospective Urgent	72 hours from the receipt of request
Prospective Non- Urgent	15 calendar days from the receipt of the request
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review 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
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A morgue or funeral home.

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services**Endodontic Therapy on Primary Teeth**

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;

- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18..

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See “Therapy Services” later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

“Emergency” or “Emergency Medical Condition” means 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: (a) place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

“Stabilize” means 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.

Emergency Care

“Emergency Care” means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See “Getting Approval for Benefits” for more details. If you or your Doctor does not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis.

Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

See "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you

coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,

- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.

- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.

6. Immunoreactive trypsin (IRT).
7. DNA testing.

[Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.]

[Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the “Preventive Care” benefit.]

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,

- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the “Home Care” benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor’s Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.

Urgent Care as described in “Urgent Care Services” later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women's contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."]

- b. Breastfeeding support, supplies, and counseling. [**Standard** Benefits for breast pumps are limited to [**1-10** one] pump per [**Standard** pregnancy] [Benefit Period].]
- c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites,

[<http://www.healthcare.gov/center/regulations/prevention.html>.] [<http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.]

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” later in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:]

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services (All Members/All Ages)" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.

- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services For Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In Network.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

Benefits do not include glasses or contact lenses except as listed in the “Prosthetics” benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- [Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at [www.anthem.com].]

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs. This tier contains higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the “Schedule of Benefits.” In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details.
- 2) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.
- 3) **Administrative Charges**
 - a) Charges to complete claim forms,
 - b) Charges to get medical records or reports,
 - c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - a. Acupuncture,
 - b. Holistic medicine,
 - c. Homeopathic medicine,
 - d. Hypnosis,
 - e. Aroma therapy,
 - f. Massage and massage therapy,
 - g. Reiki therapy,
 - h. Herbal, vitamin or dietary products or therapies,
 - i. Naturopathy,
 - j. Thermography,
 - k. Orthomolecular therapy,
 - l. Contact reflex analysis,
 - m. Bioenergetic synchronization technique (BEST),
 - n. Iridology-study of the iris,
 - o. Auditory integration therapy (AIT),
 - p. Colonic irrigation,
 - q. Magnetic innervation therapy,
 - r. Electromagnetic therapy.

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

15) Dental Services

- a) Dental care for Members age 19 or older.
- b) Dental services not listed as covered in this Booklet.
- c) Oral hygiene instructions.
- d) Case presentations.
- e) Athletic mouth guards, enamel microabrasion and odontoplasty.
- f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- h) Pulp vitality tests.
- i) Adjunctive diagnostic tests.
- j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.

- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
 - l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
 - m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
 - n) Incomplete root canals.
 - o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
 - p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - q) Provisional splinting, temporary procedures or interim stabilization.
 - r) Services of anesthesiologists, unless required by law.
 - s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
 - t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
 - u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
 - v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - w) Canal prep & fitting of preformed dowel & post.
 - x) Temporary, provisional or interim crown.
 - y) Occlusal procedures.
 - z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
 - aa) Pin retention is not covered when billed separately from restoration procedure.
 - bb) Services for the replacement of an existing partial denture with a bridge.
 - cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
 - dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
 - ee) Separate services billed when they are an inherent component of another covered service.
 - ff) Cone beam images.
 - gg) Anatomical crown exposure.
 - hh) Temporary anchorage devices.
 - ii) Sinus augmentation.
 - jj) Repair or replacement of lost/broken appliances.
- 16) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
- 17) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services,

whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the process and criteria we use to determine if a Service is Experimental or Investigational are outlined below.

- 18) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 19) **Eye Exercises** Orthoptics and vision therapy.
- 20) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 21) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 22) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
 - a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 23) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.
- 24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- 27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- 29) **Infertility Treatment** Testing or treatment related to infertility.
- 30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 31) **Medical Equipment and Supplies**

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
- 32) Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- 33) Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 34) Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 35) Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 36) Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 37) Personal Care and Convenience**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c) Home workout or therapy equipment, including treadmills and home gyms,
 - d) Pools, whirlpools, spas, or hydrotherapy equipment.
 - e) Hypo-allergenic pillows, mattresses, or waterbeds,
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- 38) Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.
- 39) Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.
- 40) Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.
- 41) Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 42) Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.
- 43) Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 44) [Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]
- 45) Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

- 46) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 47) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 48) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 49) **Vision Services**
- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
 - b) Safety glasses and accompanying frames.
 - c) For two pairs of glasses in lieu of bifocals.
 - d) Plano lenses (lenses that have no refractive power)
 - e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
 - f) Vision services not listed as covered in this Booklet.
 - g) Cosmetic lenses or options.
 - h) Blended lenses.
 - i) Oversize lenses.
 - j) Sunglasses and accompanying frames.
 - k) For services or supplies combined with any other offer, coupon or in-store advertisement.
 - l) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
 - m) Certain frames in which the manufacturer imposes a no discount policy.

- 50) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover Bariatric Surgery per mandate option] This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

- 51) **Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgeries that reduce stomach size), or gastric banding procedures].

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **[optional - Clinically-Equivalent Alternatives]** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs expected to produce similar therapeutic outcomes for a disease or

condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at [www.\[anthem\].com](http://www.[anthem].com).

If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over its clinically equivalent alternative.】

3. **Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.

[Religious group opt out to exclude Contraceptive drugs:

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.】
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com.】 If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments.
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
15. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.

16. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
18. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan. Details on the process and criteria your Plan uses to decide if a service is Experimental or Investigational are outlined below.

If you disagree with our denial of a service as Experimental or Investigational, you have the right to file a Grievance with us. Please refer the **Grievance and External Review Procedures** section of this Booklet for more information.

Process to Determine an Experimental or Investigational Service

Our process to decide whether a service is Experimental or Investigational includes medical and technical research of the service, committee review and decision, and final approval by our Chief Medical Officer.

First, our medical policy staff reviews a service based on the criteria listed in the provision below. Information on the service is gathered and combined by our Medical policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of our formal policy.

Next, the draft of the policy and literature on the service is distributed to the medical policy committee for review and discussion. The committee, which meets four times a year, is made up of a panel of Plan Physicians, most of which are actively practicing In-Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory organizations. The committee may also ask for input from one or more Physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the service, the committee recommends a final policy. The policy is forwarded to the medical policy committee chairman and Chief Medical Officer for approval.

Our policy on a service is reviewed as appropriate, every three years or less, by our medical policy staff and medical policy committee, with approval of our Chief Medical Officer and medical policy committee chairman.

We also maintain a process for deciding when existing policy on a service calls for added review and change and alerts our medical policy committee of the need to change the existing policy or make a new policy. This may come about as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change our position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by us to make policy change between regularly scheduled meetings of the medical policy committee.

Criteria to Determine an Experimental or Investigational Service

The criteria we or our designee use when making the determination of whether a Service is Experimental or Investigational when it is rendered for the evaluation or treatment of a disease, injury, illness or condition is outlined below. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Programs" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket

responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total out of pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*
- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of*

\$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.

- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of \$1500, or \$450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is \$500, you may receive a bill from the Out-of-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your In-Network Copayment of \$25, your total out of pocket expense would be \$325.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

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.

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency and urgent care obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

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, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Anthem serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Booklet.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When covered healthcare services are provided outside of our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. A Out-of-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 [(carve-out) Medicare,] 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 generally 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.

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.

“Recovery” means is money you receive from another, their insurer or from any “Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.

- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to [anthem.com](https://www.anthem.com) and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-800-368-3238] if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3 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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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.

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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and:
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

The Subscriber's spouse. For information on spousal eligibility please contact the Group.

- **[Domestic partner coverage option:[This only applies to Groups who have this option:]]** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who **[Standard when affidavit used]** has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for [12 months] or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during [an Open Enrollment period or during] a Special Enrollment period, as described below.

[Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Dependents:</u> A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits

Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

If we terminate the Group Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, we will continue your coverage for Inpatient Covered Services. Coverage will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after the Group Contract terminated;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by us;
- The Premium is not paid within the grace period shown in the Group Contract.

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Corporate Structure

The Plan is an Indiana domiciled insurance corporation owned by its stockholders and directed by a board of directors, who provide general leadership to the Plan. It is managed by a team of officers who receive direction from the board of directors and in turn direct the operations of the Plan. The Plan consists of a number of operational divisions including, but not limited to: Operations, Medical Management, Network Development, Marketing, Claims Administration, Risk Management, Legal and Member Services.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing

eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.]

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health

assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the “Schedule of Benefits” for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in “Benefits After Termination.”

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the “What’s Covered” section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Medical technology or a new application of existing medical technology, including medical procedures, Drugs, and devices for treating a medical condition, illness, or diagnosis that:

- is not generally accepted by informed health care professionals in the United States as effective; or

- has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

For how this is determined, see the “What’s Not Covered” section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient’s Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the “What’s Covered” section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Claims Payment” section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the

formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Predetermination

Please see the section “Getting Approval for Benefits ” for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 2) Insulin, diabetic supplies, and syringes.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

Anthem [Gold][Silver][Bronze] Blue Preferred [on exchange only: X] HMO

**[Insert INN Cost Share: Copay or Deductible / Coinsurance / OOP
Limit] [Plus] [w/HSA]**

_-Anthem-[Gold][Silver][Bronze]-DirectAccess-[Plus][w/HSA]



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

[on-exchange only:] If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.]

Anthem Insurance Companies, Inc.

[120 Monument Circle]
[Indianapolis, Indiana 46204]

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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, [\[www.anthem.com\]](http://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, following a pre-approved treatment plan, or procedures for making referrals. 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, [\[www.anthem.com\]](http://www.anthem.com)

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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~~If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends.~~

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

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The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
2. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

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In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

[Use with HSAs:

High-Deductible Health Plan for Use with Health Savings Accounts

This Plan is meant to be federally tax qualified and used with a qualified health savings account. Approval by the **Indiana Department of Insurance** does not guarantee tax qualification and this Plan has not been submitted for approval by the IRS. Please seek the advice of a tax advisor.]

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.


[

President]

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, Urgent Care, or Authorized Services. Please be sure to contact us if you are not sure if we have approved an Authorized Service. Benefits are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an approved Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for additional details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] [off-exchange only: Plan Year]
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

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Deductible	In-Network
[Per Member]	[\$1,250- 5,000 6,000]
[Per Family Delete for non-embedded HSA plans – All other Members combined]]	[\$2,500- 10,000 12,000]
Option for Non-Embedded HSA Plans: If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amount applies to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amount applies.) When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.	

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Coinsurance	In-Network
Plan Pays	[90%-70%]
Member Pays	[10%-30%]
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an approved Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.	

Out-of-Pocket Limit	In-Network
[Per Member]	[\$4,500-6,350 6,600]
[Per Family Delete for Non-Embedded HSA Plans – All other Members combined]]	[\$9,000-\$12,700 13,200]
Option for Non-Embedded HSA Plans: If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amount applies to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amount applies.) The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or charges for non-Covered Services. -Once the Out-of- Pocket Limit is satisfied, you will not have to pay additional [Deductibles or Coinsurance][Deductibles, Coinsurance, or Copayments] for the rest of the Benefit Period, except for the services listed above.	

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Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the

right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Ambulance Services (Air and Water)	[10%-30%] Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Ambulance Services (Ground)	[10%-30%] Coinsurance after Deductible	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	Not Covered
Behavioral Health Services	See "Mental Health and Substance Abuse Services."	Not covered
Cardiac Rehabilitation	See "Therapy Services."	Not covered
Chemotherapy	See "Therapy Services."	Not covered

Benefits	In-Network	Out-of-Network
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	Not covered
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	Not covered
Dental Services Accidental Injury Benefit Maximum	\$3,000 per Accidental Injury	Not covered
Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that we are required to cover by law.		
<u>Dental Services For Members Through Age 18</u>		
<u>Note:</u> To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• <u>Diagnostic and Preventive Services</u>	<u>10% Coinsurance after Deductible</u>	<u>Not covered</u>
• <u>Basic Restorative Services</u>	<u>40% Coinsurance after Deductible</u>	<u>Not covered</u>
• <u>Endodontic Services</u>	<u>50% Coinsurance after Deductible</u>	<u>Not covered</u>
• <u>Periodontal Services</u>	<u>50% Coinsurance after Deductible</u>	<u>Not covered</u>
• <u>Oral Surgery Services</u>	<u>50% Coinsurance after Deductible</u>	<u>Not covered</u>
• <u>Major Restorative Services</u>	<u>50% Coinsurance after Deductible</u>	<u>Not covered</u>
• <u>Prosthodontic Services</u>	<u>50% Coinsurance after Deductible</u>	<u>Not covered</u>
• <u>Dentally Necessary Orthodontic Care</u>	<u>50% Coinsurance after Deductible</u>	<u>Not covered</u>
<u>Dentally Necessary Orthodontic Care Waiting Period</u>	<u>12 months</u>	<u>Not covered</u>

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Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	Not covered
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	Not covered
[Optional/not for HSAs - Note: If you use a Preferred Diagnostic Lab (i.e., reference labs), you may not have to pay a Copayment, Deductible, or Coinsurance. Please see anthem.com for a list of these labs.]		
Dialysis	See "Therapy Services."	Not covered
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	[10%-30%] Coinsurance after Deductible	Not covered
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period	Not covered
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.		
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible [Copayment waived if admitted]	
• Emergency Room Doctor Charge	[10%-30%] Coinsurance after Deductible	

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Benefits	In-Network	Out-of-Network
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	[10%-30%] Coinsurance after Deductible	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible	
Home Care		
Home Care Visits	[10%-30%] Coinsurance after Deductible	Not covered
Home Dialysis	[10%-30%] Coinsurance after Deductible	Not covered
Home Infusion Therapy	[10%-30%] Coinsurance after Deductible	Not covered
Specialty Prescription Drugs	[10%-30%] Coinsurance after Deductible	Not covered
Other Home Care Services / Supplies	[10%-30%] Coinsurance after Deductible	Not covered
Home Care Benefit Maximum	100 visits per Benefit Period The limit does not apply to Home Infusion Therapy or Home Dialysis.	Not covered
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period 164 visits per Lifetime	Not covered
Home Infusion Therapy		
	See "Home Care."	Not covered
Hospice Care		
- Home Care - Respite Hospital Stays	0% Coinsurance after Deductible	Not covered

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	Not covered
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
• Skilled Nursing Facility	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period	Not covered
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	[10%-30%] Coinsurance after Deductible	Not covered
[For plans with hospital copay: Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.]		
[For plans with hospital copay: Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.]		
Doctor Services for:		
• General Medical Care / Evaluation and Management (E&M)	[10%-30%] Coinsurance after Deductible	Not covered
• Surgery	[10%-30%] Coinsurance after Deductible	Not covered
Maternity and Reproductive Health Services		

Benefits	In-Network	Out-of-Network
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	[10%-30%] Coinsurance after Deductible	Not covered
If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.	[Use only when office visit copay applies: The Office Visit Copayment will also apply to the first prenatal visit.]	
Inpatient Services (Delivery)	See "Inpatient Services"	Not covered
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services		
Inpatient Facility Services	[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible	Not covered
<u>Residential Treatment Center Services</u>	<u>[\$500 Copayment per admission plus] [10%-30%] Coinsurance after Deductible]</u>	<u>Not Covered</u>
Inpatient Doctor Services	[10%-30%] Coinsurance after Deductible	Not covered
Outpatient Facility Services	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
Outpatient Doctor Services	[10%-30%] Coinsurance after Deductible	Not covered
Partial Hospitalization Program / Intensive Outpatient Services	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
Office Visits	[[\$30-35] Copayment per visit for the first [3] visits, then] [10%-30%] Coinsurance after Deductible	Not covered
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.		
Occupational Therapy	See "Therapy Services."	Not covered

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Benefits	In-Network	Out-of-Network
Office Visits		
• Primary Care Physician / Provider (PCP)	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Specialty Care Physician / Provider (SCP)	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Retail Health Clinic Visit	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• Online Visit	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
• <u>Nutritional Counseling - Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)</u>	[10%-30%] Coinsurance after Deductible	Not covered
• <u>Nutritional Counseling for Eating Disorders</u>	<u>[10%-30%] Coinsurance after Deductible</u>	<u>Not covered</u>
• Allergy Testing	[10%-30%] Coinsurance after Deductible	Not covered
• Allergy Shots / Injections (other than allergy serum)	[10%-30%] Coinsurance after Deductible	Not covered
• Preferred Diagnostic Labs (i.e., reference labs)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Lab (non-preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic X-ray (non-preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Tests (non-preventive; including hearing and EKG)	[10%-30%] Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible	Not covered
• Office Surgery	[10%-30%] Coinsurance after Deductible	Not covered
• Therapy Services:		Not covered
• -- Chiropractic Care & Spinal Manipulation	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered

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Benefits	In-Network	Out-of-Network
- Physical, Speech, & Occupational Therapy	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
- Dialysis / Hemodialysis	[10%-30%] Coinsurance after Deductible	Not covered
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	[10%-30%] Coinsurance after Deductible	Not covered
- Cardiac Rehabilitation & Pulmonary Therapy	[\$30-35] Copayment per visit for the first 3 visits, then] [10%-30%] Coinsurance after Deductible	Not covered
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (includes allergy serum)	[10%-30%] Coinsurance after Deductible	Not covered
[Not for use with coinsurance only plans or HSA plans: Important Note on Office Visit Copayments: Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.]		
Orthotics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	Not covered
Outpatient Facility Services		
• Facility Surgery Charge	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
• Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	[10%-30%] Coinsurance after Deductible	Not covered
• Doctor Surgery Charges	[10%-30%] Coinsurance after Deductible	Not covered
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	[10%-30%] Coinsurance after Deductible	Not covered

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Benefits	In-Network	Out-of-Network
• Other Facility Charges (for procedure rooms or other ancillary services)	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Lab	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic X-ray	[10%-30%] Coinsurance after Deductible	Not covered
• Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	[10%-30%] Coinsurance after Deductible	Not covered
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[\$250 Copayment per visit plus] [10%-30%] Coinsurance after Deductible	Not covered
• Therapy:		
a- Chiropractic Care & Spinal Manipulation	[10%-30%] Coinsurance after Deductible	Not covered
b- Physical, Speech, & Occupational	[10%-30%] Coinsurance after Deductible	Not covered
c- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	[10%-30%] Coinsurance after Deductible	Not covered
d- Dialysis / Hemodialysis	[10%-30%] Coinsurance after Deductible	Not covered
e- Cardiac Rehabilitation & Pulmonary Therapy	[10%-30%] Coinsurance after Deductible	Not covered
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in an Outpatient Facility	[10%-30%] Coinsurance after Deductible	Not covered
Physical Therapy	See "Therapy Services."	Not covered
Preventive Care	No Copayment, Deductible, or Coinsurance	Not covered

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Benefits	In-Network	Out-of-Network
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	Not covered
Pulmonary Therapy	See "Therapy Services."	Not covered
Radiation Therapy	See "Therapy Services."	Not covered
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Respiratory Therapy	See "Therapy Services."	Not covered
Skilled Nursing Facility	See "Inpatient Services."	Not covered
Speech Therapy	See "Therapy Services."	Not covered
Surgery	Benefits are based on the setting in which Covered Services are received.	Not covered
[<i>optional offer mandate – add when selected</i>] Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime]	Not covered
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	Not covered
Therapy Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Benefit Maximum(s):	Benefit Maximum(s) are for office and outpatient visits combined.	Not covered
Physical Therapy	20 visits per Benefit Period	Not covered

Benefits	In-Network	Out-of-Network
• Occupational Therapy	20 visits per Benefit Period	Not covered
• Speech Therapy	20 visits per Benefit Period	Not covered
• Manipulation Therapy	20 visits per Benefit Period	Not covered
• Cardiac Rehabilitation	36 visits per Benefit Period	Not covered
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	Not covered
Urgent Care Services (Office Visit)		
• Urgent Care Office Visit Charge	[10%-30%] Coinsurance after Deductible	
• Allergy Testing	[10%-30%] Coinsurance after Deductible	
• Allergy Shots / Injections (other than allergy serum)	[10%-30%] Coinsurance after Deductible	
• Preferred Diagnostic Labs (i.e., reference labs)	[10%-30%] Coinsurance after Deductible	
• Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	[10%-30%] Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[10%-30%] Coinsurance after Deductible	
• Office Surgery	[10%-30%] Coinsurance after Deductible	
• Prescription Drugs Administered in the Office (includes allergy serum)	[10%-30%] Coinsurance after Deductible	

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Benefits	In-Network	Out-of-Network
If you see an Out-of-Network Provider, that Provider may also bill you for any charges over the Plan's Maximum Allowed Amount.		
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		

Vision Services For Members Through Age 18 Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam	\$0 Copayment	Not covered
Limited to one exam per Benefit Period		
Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Not covered
Bifocal	\$0 Copayment	Not covered
Trifocal	\$0 Copayment	Not covered
Progressive	\$0 Copayment	Not covered
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.		
Frames	\$0 Copayment	Not covered
Limited to one set of frames from the Anthem Formulary per Benefit Period.		
Contact Lenses		
Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.		

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Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Not covered
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Not covered
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		
	Benefits are based on the setting in which Covered Services are received.	Not covered

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further information.)

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call	Not covered

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	the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	
	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, [Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
• Precertification required	Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits or Office Visits depending where the service is performed.	
	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
Covered Transplant Procedure during the Transplant Benefit Period	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
Transportation and Lodging	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered
• Transportation and Lodging Limit	Covered, as approved by us, up to [\$10,000] per transplant	Not covered
Unrelated donor searches from an authorized,	[Standard: No Copayment	Not covered

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licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure		/ Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	
• Donor Search Limit	Covered, as approved by us, up to [\$30,000] per transplant.	Not covered	
Live Donor Health Services	[Standard: No Copayment / Deductible / Coinsurance up to the Maximum Allowed Amount.] [HSA - 10% Coinsurance after Deductible]	Not covered	
• Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Not covered	

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Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits

Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.

[Option: Prescription Drug Deductible (waived for Tier 1)]

Per Member [\$250, 750]

Per Family [\$500, 1,500]

[2014 Option: Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.]

[Option: Prescription Drug Out of Pocket Limit]

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Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits							
Per Member	\$6,350						
Per Family	\$12,700						
[2014 Option: Note: The Prescription Drug Out-of-Pocket Limit is separate and does not apply toward any other Out-of-Pocket Limit for Covered Services in this Plan. It includes all Deductibles, Coinsurance, and Copayments you pay for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy during a Benefit Period. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.] [2014 Option if Separate Rx OOP: Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy for the rest of the Benefit Period.]]							
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines. <table> <tr> <td>Retail Pharmacy</td><td>30 days</td></tr> <tr> <td>Home Delivery (Mail Order) Pharmacy</td><td>90 days</td></tr> <tr> <td>Specialty Pharmacy</td><td>30 days*</td></tr> </table> *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.		Retail Pharmacy	30 days	Home Delivery (Mail Order) Pharmacy	90 days	Specialty Pharmacy	30 days*
Retail Pharmacy	30 days						
Home Delivery (Mail Order) Pharmacy	90 days						
Specialty Pharmacy	30 days*						

	In-Network	Out-of-Network
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$15 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 2 Prescription Drugs	[\$35, 50 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 3 Prescription Drugs	[\$70, 90 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 4 Prescription Drugs	[10%, 30% Coinsurance] [to a maximum of \$500] per Prescription Drug [after Deductible]	Not covered

**Home Delivery Pharmacy
Copayments / Coinsurance:**

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Tier 1 Prescription Drugs	[\$38 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 2 Prescription Drugs	[\$88, 125 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 3 Prescription Drugs	[\$175, 225 Copayment] [10% Coinsurance] per Prescription Drug [after Deductible]	Not covered
Tier 4 Prescription Drugs	[10%, 30% Coinsurance] [to a maximum of \$500] per Prescription Drug [after Deductible]	Not covered

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Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

[Optional:

Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will be have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.]

[Standard: Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]

[HSA plans Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when you get them from an In-Network Pharmacy. These supplies are not covered if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]

**Orally Administered Cancer
Chemotherapy**

[Use with all regular plans - No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.]

[Use with HSA coinsurance plans - Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.]

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.

How Your Plan Works

Introduction

Your Plan is a HMO plan. To get benefits for Covered Services, you must use In-Network Providers, unless we have approved an Authorized Service or if your care involves an Emergency or Urgent Care situation.

In-Network Provider Services

When you get care from an In-Network Provider or as part of an Authorized Service, benefits are available for Covered Services. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

Primary Care Physicians / Providers (PCP)

PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, and geriatricians. Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

If, when you first enroll (sign up) for coverage under this Plan, you are under the care of an Out-of-Network Provider, you should tell us right away. To keep getting care under this Plan from any Out-of-Network Provider, we must approve an Authorized Service with that Provider or the services will be denied.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any In-Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call us at the telephone number listed on the back of your Identification Card.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Off exchange only: Guest Memberships

When you or any of your covered dependents will be staying temporarily outside of the Service Area for more than 90 days, you can request a guest membership to a Blue Cross and Blue Shield affiliated health maintenance organization in that area. An example of when this service may be utilized is when a Dependent student attends a school outside of the service area. Call Customer Services at the number on the back of your ID card to make sure that the area in which you or your Dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated health maintenance organization plans. If the area is within the network, you will need to complete a guest membership application and you will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield health maintenance organization affiliate where you or your covered Dependents will be staying. A Customer Services representative will explain any limitations or restrictions to this benefit. If you are staying in an area that is not within the Guest Membership Network, this service will not be available.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

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Service Area

The Service Area for this Plan is the State of Indiana.

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Enhanced Personal Health Care Patient-Centered Primary Care Program

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Certain Primary Care Providers are part of our **Enhanced Personal Health Care Patient-Centered Primary Care** Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

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Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in our Service Area. If you are receiving care from an In-Network Provider whose contractual relationship with us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated In-Network Provider for a set period.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

[Off-exchange only-Crediting Prior Plan Coverage

If You were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then You will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If Your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and You were covered by the other product immediately before enrolling in this product with no break in coverage, then You may get credit for any accrued Deductible and Out-of-Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If Your Group offers more than one of our products, and You change from one product to another with no break in coverage, You will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If Your Group offers coverage through other products or carriers in addition to ours, and You change products or carriers to enroll in this product with no break in coverage, You will get credit for any accrued Deductible, Out-of-Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your group moves to this Plan at the beginning of a Benefit Period;
- You Change from one of our individual policies to a group plan;
- You Change employers; or
- You Are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need Emergency or urgent care services as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details. Please note that you only have coverage for Emergency and urgent care health care services when traveling outside the United States.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.

- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

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Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by an Out-of-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for an Out-of-Network Provider unless: - You get authorization to use an Out-of-Network Provider before the service is given; or - For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

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We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

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Request Categories

- Emergent Urgent – A** request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

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- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review**- A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an inpatient admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

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Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective Emergent/Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non- Emergent/Urgent	2 business days from the receipt of the request
Continued Stay Review Emergent/Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent/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
Continued Stay Review Non- Emergent/Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	
Prospective Emergent/Urgent	72 hours from the receipt of request
Prospective Non- Emergent/Urgent	15 calendar days from the receipt of the request
Continued Stay Review Emergent/Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent/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
Continued Stay Review Non- Emergent/Urgent	15 calendar days from the receipt of the request

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If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a ~~covered benefit~~ Covered Service under your Plan;
4. The service cannot be subject to an exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

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Health Plan Individual Case Management

~~Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.~~

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~~Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.~~

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~~Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.~~

~~Our Case Management programs are confidential and voluntary. These programs are given at no extra cost to you.~~

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your ~~chosen~~ authorized representative, treating Doctor(s), and other Providers.

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In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop

providing extended benefits or approving alternate care. In such case, we will notify you or your
| authorized representative in writing.

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What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

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Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers

Recent Space Maintainer

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration

Pin Retention – per tooth, in addition to restoration.

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Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty
- Gingival flap:
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;

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- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

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Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

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Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

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Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

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If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recent Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

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If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- **Limited Treatment** - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- **Interceptive Treatment** - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- **Comprehensive (complete) Treatment** - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- **Removable Appliance Therapy** - An appliance that is removable and not cemented or bonded to the teeth.
- **Fixed Appliance Therapy** - A component that is cemented or bonded to the teeth.
- **Other Complex Surgical Procedures** - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

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Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;

- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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: (a)

place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means 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.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will not be covered unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

See "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** has been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

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Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered **benefits Services** for transportation and lodging include, but are not limited to:

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- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,

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- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.]

[Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.]

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape.

Comment [tdw6]: New mandate for 2014

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- Inpatient Services in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- Outpatient Services including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often.
 - Rehabilitation, therapy, and education.
- Inpatient Services in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation.
- Outpatient Services including treatment in an outpatient department of a Hospital and office visits.

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- **Day Treatment Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.

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You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care" benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in "Urgent Care Services" later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

- e-a. [Women's contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."]
- e-b. Breastfeeding support, supplies, and counseling. [Standard Benefits for breast pumps are limited to [1-10 one] pump per [Standard pregnancy] [Benefit Period].]
- e-c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites, [\[http://www.healthcare.gov/center/regulations/prevention.html\]](http://www.healthcare.gov/center/regulations/prevention.html), [\[http://www.ahrq.gov\]](http://www.ahrq.gov), and [http://www.cdc.gov/vaccines/acip/index.html\]](http://www.cdc.gov/vaccines/acip/index.html)

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" later in this Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:]

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services [\(All Members/All Ages\)](#)" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and

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- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

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Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "[Prescription Drugs Administered by a Medical Provider](#)" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than

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30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “[Prescription Drugs Administered by a Medical Provider](#)” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

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Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

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Vision Services For Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In Network.

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating.

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Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" benefit.

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Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

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Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

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Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- [Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. Smoking-cessation-products-and

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~~over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription.~~ These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.]

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

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We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

[Standard for all plans except HSA:

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.]

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1) Abortion Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a Doctor.

2) Acts of War, Disasters, or Nuclear Accidents In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

3) Administrative Charges

a) Charges to complete claim forms,

b) Charges to get medical records or reports,

c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

4) Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

a) Acupuncture,

b) Holistic medicine,

c) Homeopathic medicine,

d) Hypnosis,

e) Aroma therapy,

f) Massage and massage therapy,

g) Reiki therapy,

h) Herbal, vitamin or dietary products or therapies,

i) Naturopathy,

j) Thermography,

k) Orthomolecular therapy,

l) Contact reflex analysis,

m) Bioenergetic synchronization technique (BEST),

n) Iridology-study of the iris,

o) Auditory integration therapy (AIT),

p) Colonic irrigation,

q) Magnetic innervation therapy,

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or, Electromagnetic therapy.

5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]

11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.

12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence. This Exclusion does not apply if you were the victim of a crime, including domestic violence.

14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

Dental Treatment Dental treatment, except as listed below.

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;
- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded.

This Exclusion does not apply to services that we must cover by law.

15) Dental Services

a) Dental care for Members age 19 or older.

b) Dental services not listed as covered in this Booklet.

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c) Oral hygiene instructions.	Formatted	... [1]
d) Case presentations.	Formatted	... [2]
e) Athletic mouth guards, enamel microabrasion and odontoplasty.	Formatted	... [3]
f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.	Formatted	... [4]
g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.	Formatted	... [5]
h) Pulp vitality tests.	Formatted	... [6]
i) Adjunctive diagnostic tests.	Formatted	... [7]
j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.	Formatted	... [8]
k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.	Formatted	... [9]
l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).	Formatted	... [10]
m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.	Formatted	... [11]
n) Incomplete root canals.	Formatted	... [12]
o) Bacteriologic tests for determination of periodontal disease or pathologic agents.	Formatted	... [13]
p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.	Formatted	... [14]
q) Provisional splinting, temporary procedures or interim stabilization.	Formatted	... [15]
r) Services of anesthesiologists, unless required by law.	Formatted	... [16]
s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.	Formatted	... [17]
t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.	Formatted	... [18]
u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.	Formatted	... [19]
v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.	Formatted	... [20]
w) Canal prep & fitting of preformed dowel & post.	Formatted	... [21]
x) Temporary, provisional or interim crown.	Formatted	... [22]
y) Occlusal procedures.	Formatted	... [23]
z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.	Formatted	... [24]
aa) Pin retention is not covered when billed separately from restoration procedure.	Formatted	... [25]
bb) Services for the replacement of an existing partial denture with a bridge.	Formatted	... [26]
cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).	Formatted	... [27]

dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

ee) Separate services billed when they are an inherent component of another covered service.

ff) Cone beam images.

gg) Anatomical crown exposure.

hh) Temporary anchorage devices.

ii) Sinus augmentation.

jj) Repair or replacement of lost/broken appliances.

- 16) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

- 17) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the process and criteria we use to determine if a Service is Experimental or Investigational are outlined below.

- 18) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

- 19) **Eye Exercises** Orthoptics and vision therapy.

- 20) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

- 21) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

- 22) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

ea) Cleaning and soaking the feet.

eb) Applying skin creams to care for skin tone.

ec) Other services that are given when there is not an illness, injury or symptom involving the foot.

- 23) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.

- 24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

- 25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

- 26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

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- 27) Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 28) Home Care**
 - a)** Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b)** Food, housing, homemaker services and home delivered meals.
- 29) Infertility Treatment** Testing or treatment related to infertility.
- 30) Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 31) Medical Equipment and Supplies**
 - a)** Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b)** Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c)** Non-Medically Necessary enhancements to standard equipment and devices.
- 32) Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- 33) Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 34) Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 35) Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 36) Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Urgent Care, or Authorized Services.
- 37) Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 38) Personal Care and Convenience**
 - a)** Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b)** First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c)** Home workout or therapy equipment, including treadmills and home gyms,
 - d)** Pools, whirlpools, spas, or hydrotherapy equipment.
 - e)** Hypo-allergenic pillows, mattresses, or waterbeds,
 - f)** Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

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•39) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.

•40) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

• ~~Providers Services you get from a non-covered Provider, as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.~~

• ~~Residential Treatment Centers Unless we must cover them by law.~~

•41) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.

•42) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

•43) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.

•44) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

•45) **[Religious group opt out to exclude: Sterilization** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]

•46) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

•47) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

•48) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

•49) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

•50) **Vision Services**

ea) Vision services for Members age 19 or older, unless listed as covered in this Booklet.

eb) Safety glasses and accompanying frames.

ec) For two pairs of glasses in lieu of bifocals.

ed) Plano lenses (lenses that have no refractive power)

ee) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.

ef) Vision services not listed as covered in this Booklet.

eg) Cosmetic lenses or options.

eh) Blended lenses.

ei) Oversize lenses.

ej) Sunglasses and accompanying frames.

ek) For services or supplies combined with any other offer, coupon or in-store advertisement.

el) For Members through age 18, no benefits are available for frames not on the Anthem formulary.

em) Certain frames in which the manufacturer imposes a no discount policy.

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- **51) Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover **Bariatric Surgery per mandate option** This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

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- **52) Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures].

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What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

- **1. Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

[Optional:

- **2. Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at www.janthem.com.

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If you or your Physician believe you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE. We will cover your current Prescription Drug only if We agree that it is Medically Necessary and appropriate over its clinically equivalent alternative.]

- **3. Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer ~~Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.~~

[Religious opt out to exclude Contraceptive Drugs:

- **4. Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]
- **5. Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

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- **6. Delivery Charges** Charges for delivery of Prescription Drugs.
- **7. Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.

- | ♦ **8. Drugs Not on the Anthem Prescription Drug List (a formulary).** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Physician believe you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
- | ♦ **9. Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- | ♦ **10. Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
- | ♦ **11. Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- | ♦ **12. Fluoride Treatments** Topical and oral fluoride treatments.
- | ♦ **13. Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
- | ~~1-14.~~ **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
- | ♦ **15. Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
- | ~~2-16.~~ **Items Covered Under the "Allergy ServicesAllergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
- | ♦ **17. Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- | ♦ **18. Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
- | ♦ **19. Non-approved Drugs** Drugs not approved by the FDA.
- | ♦ **20. Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- | ♦ **21. Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- | ♦ **22. Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

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This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.

- 23. Sex Change Drugs** Drugs for sex change surgery.
- 24. Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
- 25. Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- 26. Weight Loss Drugs** Any Drug mainly used for weight loss.

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EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan. Details on the process and criteria your Plan uses to decide if a service is Experimental or Investigational are outlined below.

If you disagree with our denial of a service as Experimental or Investigational, you have the right to file a Grievance with us. Please refer the **Grievance and External Review Procedures** section of this Booklet for more information.

Process to Determine an Experimental or Investigational Service

Our process to decide whether a service is Experimental or Investigational includes medical and technical research of the service, committee review and decision, and final approval by our Chief Medical Officer.

First, our medical policy staff reviews a service based on the criteria listed in the provision below. Information on the service is gathered and combined by our Medical policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of our formal policy.

Next, the draft of the policy and literature on the service is distributed to the medical policy committee for review and discussion. The committee, which meets four times a year, is made up of a panel of Plan Physicians, most of which are actively practicing In-Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory organizations. The committee may also ask for input from one or more Physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the service, the committee recommends a final policy. The policy is forwarded to the medical policy committee chairman and Chief Medical Officer for approval.

Our policy on a service is reviewed as appropriate, every three years or less, by our medical policy staff and medical policy committee, with approval of our Chief Medical Officer and medical policy committee chairman.

We also maintain a process for deciding when existing policy on a service calls for added review and change and alerts our medical policy committee of the need to change the existing policy or make a new policy. This may come about as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change our position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by us to make policy change between regularly scheduled meetings of the medical policy committee.

Criteria to Determine an Experimental or Investigational Service

The criteria we or our designee use when making the determination of whether a Service is Experimental or Investigational when it is rendered for the evaluation or treatment of a disease, injury, illness or

condition is outlined below. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

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Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Out-of-Area Services" [Inter-Plan Programs](#) later in this section for additional information.

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The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

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You will be required to pay a portion of the Maximum Allowed Amount to the extent you have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under this product are not covered except for Emergency Care, or when allowed as an Authorized Service by us. When you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency Care, or unless the services are approved by us as an Authorized Service.

For Covered Services You receive from an Out-of-Network Provider for Emergency Care or for services approved as an Authorized Service, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the

Provider will render. You will also need to know the Provider's charges to calculate your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using prescription drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

If you receive Covered Services in an In-Network Provider facility from an Out-of-Network Provider, such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with the In-Network Hospital or facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency Care or Urgent Care services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

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Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

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Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a

Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

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Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("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.

Typically, when accessing care outside Anthem's Service Area and the Service Area of Anthem's corporate parent, 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 non-participating healthcare Providers. Anthem's payment practices in both instances are described below.

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care and urgent care obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your Primary Care Physician ("PCP").

BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area 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.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount, as stated in your Booklet.

Emergency Care Services: If you experience a Medical Emergency while traveling outside the Anthem Service Area, go to the nearest Emergency or Urgent Care Facility.

Whenever you access covered healthcare services outside Anthem's and, if applicable, Anthem's corporate parent's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special

arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. A Out-of-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 [(carve-out) Medicare,] 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

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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

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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.

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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

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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 generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment

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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.

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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.

"Recovery" means is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

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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:

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- 1. The amount we paid on your behalf is not repaid or otherwise recovered by us; or
- 2. you fail to cooperate.

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- 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.

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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.

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Your Member Rights and Responsibilities as an Anthem Blue Cross and Blue Shield Member

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.

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• Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.

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• Follow the care plan that you have agreed on with your Doctors or health care Providers.

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• Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.

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• Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

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We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

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If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

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As an Anthem Blue Cross and Blue Shield (Anthem) Member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights" and helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- ~~Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your Plan.~~
- ~~Work with your doctors in making choices about your health care.~~
- ~~Be treated with respect, dignity, and the right to privacy.~~
- ~~Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.~~
- ~~Get information about our company and services, and our network of doctors and other health care Providers.~~
- ~~Get more information about your rights and responsibilities and give us your thoughts and ideas about them.~~
- ~~Give us your thoughts and ideas about any of the rules of your Plan and in the way your Plan works.~~
- ~~Make a complaint or file an appeal about:
 - o ~~Your Plan~~
 - o ~~Any care you get~~
 - o ~~Any Covered Service or benefit ruling that your Plan makes.~~~~
- ~~Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.~~
- ~~Participate in matters that deal with our policies and operations.~~
- ~~Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information that information will be given to someone else that you choose.~~
- ~~Get help at any time, by contacting your local insurance department.~~

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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.~~

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- ~~Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.~~
- ~~To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.~~
- ~~Follow the care plan that you have agreed on with your doctors or health care professionals.~~
- ~~Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.~~
- ~~Follow all Plan rules and policies.~~
- ~~Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.~~
- ~~Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.~~

~~For details about your coverage and benefits, please read the rest of this Booklet.~~

~~**We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.**~~

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

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Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-317800-287368-59683238](tel:1-317800-287368-59683238) if you wish to file your Grievance by fax.

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For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3 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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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.

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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 utilization review determination; 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 Booklet; 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~~
- ~~The service is not specifically excluded in this Booklet.~~

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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 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.]

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Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

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Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- **The Subscriber's spouse.** For information on spousal eligibility please contact the Group.
- **[Domestic partner coverage: This only applies to Groups who have this option:]** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who [Standard when affidavit used] has signed the Domestic Partner Affidavit certifying that he or she is the Subscriber's sole Domestic Partner and has been for [12 months] or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

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For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard when affidavit used:] To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

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All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- 1. For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

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We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

~~Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Plan unless required by the laws of this state.~~

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- ~~Subscriber and one child;~~
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll [during an Open Enrollment period or] during a Special Enrollment period, as described below.

[Open Enrollment

Open Enrollment refers to a period of time, usually [60 days], during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted

otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- ~~Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.~~
- ~~Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.~~
- ~~Lost employer contributions towards the cost of the other coverage.~~
- ~~Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.~~
- ~~Lost eligibility under a prior health plan for reasons other than non-payment of premium (or contribution to premium) or due to fraud or intentional misrepresentation of a material fact.~~
- ~~Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.~~
- ~~Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.~~

Important Notes about Special Enrollment:

1. ~~Members who enroll during Special Enrollment are **not** considered Late Enrollees.~~
2. ~~Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).~~
3. ~~Evidence of prior creditable coverage is required and must be furnished by you or your prior carrier.~~

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

1. ~~The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or~~
2. ~~The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)~~

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The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, **they may apply for coverage at any time during the year as a Late Enrollee.** ~~However, you will~~ not be eligible to enroll until the next Open Enrollment Period.}

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Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- 2. The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- 3. Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

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Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the

applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

~~No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.~~

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

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Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- | •• When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | •• If you choose to terminate your coverage. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | •• If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | •• If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | •• If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"
- | • If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents. Formatted: Indent: Left: 0", Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- | • If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse. Formatted: Indent: Left: 0", Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"
- | •• If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area. Formatted: Bulleted + Level: 1 + Aligned at: 0" + Indent at: 0.25"

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another Group health plan.

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Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

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Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u>	
Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
<u>For Dependents:</u>	
A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

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If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

If we terminate the Group Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, we will continue your coverage for Inpatient Covered Services. Coverage will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after the Group Contract terminated;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by us;
- The Premium is not paid within the grace period shown in the Group Contract.

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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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

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The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

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Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

- 1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
- 2. 24 months from the date your leave began.

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Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

- 1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

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- ♦2. 14 days of completing your military service for leaves of 31 to 180 days; or
- ♦3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

- ♦1. Two years; or
- ♦2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

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General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Corporate Structure

The Plan is an Indiana domiciled insurance corporation owned by its stockholders and directed by a board of directors, who provide general leadership to the Plan. It is managed by a team of officers who receive direction from the board of directors and in turn direct the operations of the Plan. The Plan consists of a number of operational divisions including, but not limited to: Operations, Medical Management, Network Development, Marketing, Claims Administration, Risk Management, Legal and Member Services.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

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Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled.

You should enroll in Medicare Part B as soon as possible to avoid potential liability.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing

eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives

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such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.) We may offer health or fitness related program options for purchase by your Group. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed and could be discontinued at any time. If your Group has selected one of these options, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors when administered according to state or federal law. However, if it is unreasonably difficult due to a medical condition for you to achieve the standards for a reward under such a program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive gift cards and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

- ~~6-1.~~ Is licensed as required;
- ~~7-2.~~ Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
- ~~8-3.~~ Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
- ~~9-4.~~ Does not have Inpatient accommodations; and
- ~~10-5.~~ Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "Benefits After Termination."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Medical technology or a new application of existing medical technology, including medical procedures, Drugs, and devices for treating a medical condition, illness, or diagnosis that:

- is not generally accepted by informed health care professionals in the United States as effective; or

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- has not been proven by scientific testing or evidence to be effective;
- in treating the medical condition, illness, or diagnosis for which its use is proposed.
- For how this is determined, see the "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "~~Eligibility and Enrollment – Adding Members~~~~Eligibility and Enrollment – Adding Members~~" section for further details.

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Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

[Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.]

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

~~The most you pay during a Benefit Period for Covered Services before your Plan begins benefits. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Schedule of Benefits" for details.~~

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

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Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Predetermination

Please see the section "Getting Approval for Benefits" for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
- 2) Insulin, diabetic supplies, and syringes.

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Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

~~A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Covered Providers are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.~~

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Recovery

Please see the “Subrogation and Reimbursement” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by state regulatory agencies.

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Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

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Certificate of Coverage

(Referred to as "Booklet" in the following pages)

**Anthem Bronze Blue Preferred [on exchange only: X] POS 6000/30%/6600
PlusAnthem Bronze DirectAccess Plus**



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

[on-exchange only:] If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.]

Anthem Insurance Companies, Inc.
[120 Monument Circle]
[Indianapolis, Indiana 46204]

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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, [\[www.anthem.com\]](http://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, [\[www.anthem.com\]](http://www.anthem.com)

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

~~If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends.~~

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:]

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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/doi

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

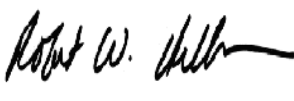
This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.



President

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] <u>[off-exchange only: Plan Year]</u>
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

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Deductible	In-Network	Out-of-Network
Per Member	\$5 6,000	\$10 12,000
Per Family - All other Members combined	\$10 12,000	\$20 24,000
The In-Network and Out-of-Network Deductibles are separate and cannot be combined.		
When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.		
Copayments and Coinsurance are separate from and do not apply to the Deductible.		

Coinsurance	In-Network	Out-of-Network
Plan Pays	70%	50%
Member Pays	30%	50%
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.		
Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	\$6,350 6,600	\$12,700 13,200
Per Family – All other Members combined	\$12,700 13,200	\$25,400 26,400
The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.		
The Out-of-Pocket Limit does not include amounts you pay for following benefits:		
Out-of-Network Human Organ and Tissue Transplant services.		
Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above.		
The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network	Formatted Table
Allergy Services	Benefits are based on the setting in which Covered Services are received.		
Ambulance Services (Air and Water)	30% Coinsurance after Deductible		
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.			
			Formatted Table
Ambulance Services (Ground)	30% Coinsurance after Deductible		
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.			
			Formatted Table
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.		
Behavioral Health Services	See "Mental Health and Substance Abuse Services."		
Cardiac Rehabilitation	See "Therapy Services."		
Chemotherapy	See "Therapy Services."		
Clinical Trials	Benefits are based on the setting in which Covered Services are received.		

Benefits	In-Network	Out-of-Network
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	
Dental Services Accidental Injury Benefit Maximum	\$3,000 per Accidental Injury In- and Out-of-Network combined	
Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that we are required to cover by law.		
Dental Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
Diagnostic and Preventive Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Basic Restorative Services	40% Coinsurance after Deductible	50% Coinsurance after Deductible
Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
per incident limit		
Dentally Necessary Orthodontic Care Waiting Period		12 Months
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	

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Benefits	In-Network	Out-of-Network
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Wigs Needed After Cancer Treatment Benefit Maximum The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.	One wig per Benefit Period In- and Out-of-Network combined	
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	\$250 Copayment per visit plus 30% Coinsurance after Deductible	Copayment waived if admitted
Emergency Room Doctor Charge	30% Coinsurance after Deductible	
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	
Home Care		
Home Care Visits	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Dialysis	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Infusion Therapy	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Benefits	In-Network	Out-of-Network
Specialty Prescription Drugs	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Home Care Services / Supplies	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period In- and Out-of-Network combined	
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period In- and Out-of-Network combined	
	164 visits per Lifetime In- and Out-of-Network combined	
Home Infusion Therapy	See “Home Care.”	
Hospice Care		
- Home Care - Respite Hospital Stays	0% Coinsurance after Deductible	50% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Benefits	In-Network	Out-of-Network	Formatted Table
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.			
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.			
Doctor Services for:			Formatted Table
General Medical Care / Evaluation and Management (E&M)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Maternity and Reproductive Health Services			
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	30% Coinsurance after Deductible	50% Coinsurance after Deductible	
If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.			
Inpatient Services (Delivery)	See "Inpatient Services"		
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.			
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Mental Health and Substance Abuse Services			
Inpatient Facility Services	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible	
Residential Treatment Center Services	\$500 Copayment per admission plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible	Comment [tdw2]: Added for MHP compliance
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Inpatient Doctor Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible	Formatted: Highlight
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Outpatient Facility Services	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
Outpatient Doctor Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Office Visits	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.		
Occupational Therapy	See "Therapy Services."	
Office Visits		
Primary Care Physician / Provider (PCP)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Specialty Care Physician / Provider (SCP)	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Retail Health Clinic Visit	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Online Visit	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
<u>Nutritional Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)</u>	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Benefits	In-Network	Out-of-Network
• <u>Nutritional Counseling for Eating Disorders</u>	<u>\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible</u>	<u>50% Coinsurance after Deductible</u>
• Allergy Testing	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (other than allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Lab (non-preventive)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic X-ray (non-preventive)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Tests (non-preventive; including hearing and EKG)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Therapy Services:		
- Chiropractic Care & Spinal Manipulation	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
- Physical, Speech, & Occupational Therapy	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
- Dialysis / Hemodialysis	30% Coinsurance after Deductible	50% Coinsurance after Deductible
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	30% Coinsurance after Deductible	50% Coinsurance after Deductible
- Cardiac Rehabilitation & Pulmonary Therapy	\$35 Copayment per visit for the first 3 visits, then 30% Coinsurance after Deductible	50% Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		

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Benefits	In-Network	Out-of-Network
Prescription Drugs Administered in the Office (includes allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.		
Orthotics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	
Outpatient Facility Services		
Facility Surgery Charge	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Doctor Surgery Charges	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Lab	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic X-ray	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	\$250 Copayment per visit plus 30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Benefits	In-Network	Out-of-Network
- Therapy: - Chiropractic Care & Spinal Manipulation - Physical, Speech, & Occupational - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Dialysis / Hemodialysis - Cardiac Rehabilitation & Pulmonary Therapy See "Therapy Services" for details on Benefit Maximums. - Prescription Drugs Administered in an Outpatient Facility	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible
Physical Therapy	See "Therapy Services."	
Preventive Care	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Pulmonary Therapy	See "Therapy Services."	
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See "Therapy Services."	

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Benefits	In-Network	Out-of-Network
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	See "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received.	
[optional offer mandate – add when selected –Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime In- and Out-of-Network combined]	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
Physical Therapy	20 visits per Benefit Period	
Occupational Therapy	20 visits per Benefit Period	
Speech Therapy	20 visits per Benefit Period	
Manipulation Therapy	20 visits per Benefit Period	
Cardiac Rehabilitation	36 visits per Benefit Period	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	

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Benefits	In-Network	Out-of-Network
Urgent Care Services (Office Visits)		
• Urgent Care Office Visit Charge	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Testing	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (other than allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery	30% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (includes allergy serum)	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Vision Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
• Routine Eye Exam	\$0 Copayment	Covered up to \$30
Limited to one exam per Benefit Period		
• Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Covered up to \$25

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Benefits	In-Network	Out-of-Network
Bifocal	\$0 Copayment	Covered up to \$40
Trifocal	\$0 Copayment	Covered up to \$55
Progressive	\$0 Copayment	Covered up to \$40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.		
Frames	\$0 Copayment	Covered up to \$45
Limited to one set of frames from the Anthem Formulary per Benefit Period.		
Contact Lenses		
Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		
Benefits are based on the setting in which Covered Services are received.		

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Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further details.)

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services, related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of- Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
• Precertification required	During the Transplant Benefit Period, no Copayment / Deductible / Coinsurance.	During the Transplant Benefit Period, You will pay 50% Coinsurance after Deductible.

	Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers No Copayment / Deductible / Coinsurance	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers 50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.

• Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant In- and Out-of-Network combined	Limit.
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible
		These charges will NOT apply to your Out-of-Pocket Limit.
• Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant In- and Out-of-Network combined	
Live Donor Health Services	No Copayment / Deductible / Coinsurance	50% Coinsurance after Deductible
		These charges will NOT apply to your Out-of-Pocket Limit.
• Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Prescription Drug Deductible (waived for Tier 1)		
<u>Per Member</u>	<u>\$250 In- and Out-of-Network combined</u>	
<u>Per Family</u>	<u>\$500 In- and Out-of-Network combined</u>	
<u>Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.</u>		
Prescription Drug Out-of-Pocket Limit		
Per Member	\$6,350 In- and Out-of-Network combined	
Per Family	\$12,700 In- and Out-of-Network combined	
[2014 Option: Note: The Prescription Drug Out of Pocket Limit is separate and does not apply toward any other Out of Pocket Limit for Covered Services in this Plan. It includes all Deductibles, Coinsurance, and Copayments you pay for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy during a Benefit Period. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]		
[2014 Option if Separate Rx OOP: Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy for the rest of the Benefit Period.]		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy (In-Network and Out-of-Network)	30 days*	
	*See additional information in the "Specialty Drug Copayments / Coinsurance" section below.	
Retail Pharmacy Copayments / Coinsurance:		

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Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 1 Prescription Drugs	\$15 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 2 Prescription Drugs	\$35 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 3 Prescription Drugs	\$70 Copayment per Prescription Drug	50% Coinsurance per Prescription Drug
Tier 4 Prescription Drugs	\$30% Coinsurance to a maximum of \$500 per Prescription Drug	50% Coinsurance per Prescription Drug
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$38 Copayment per Prescription Drug	Not Covered
Tier 2 Prescription Drugs	\$88 Copayment per Prescription Drug	Not Covered
Tier 3 Prescription Drugs	\$175 Copayment per Prescription Drug	Not Covered
Tier 4 Prescription Drugs	\$30% Coinsurance to a maximum of \$500 per Prescription Drug	Not Covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy. [Optional: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.]		

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.		
Orally Administered Cancer Chemotherapy	No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In--Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network.	
	No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-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.	

How Your Plan Works

Introduction

Your Plan is a Point of Service (POS) plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

Service Area

The Service Area for this Plan is the State of Indiana.

[PC2 option:

Enhanced Personal Health Care ~~Patient-Centered Primary Care~~ Program

Certain Primary Care Providers are part of our **Enhanced Personal Health Care** ~~Patient-Centered Primary Care~~ Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in our Service Area. If you are receiving care from an In-Network Provider whose contractual relationship with us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated In-Network Provider for a set period.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

Off exchange only: Crediting Prior Plan Coverage

If You were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then You will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If Your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and You were covered by the other product immediately before enrolling in this product with no break in coverage, then You may get credit for any accrued Deductible and Out-of-Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If Your Group offers more than one of our products, and You change from one product to another with no break in coverage, You will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If Your Group offers coverage through other products or carriers in addition to ours, and You change products or carriers to enroll in this product with no break in coverage, You will get credit for any accrued Deductible, Out-of-Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your group moves to this Plan at the beginning of a Benefit Period;
- You Cchange from one of our individual policies to a group plan;
- You Cchange employers; or
- You aAre a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need Emergency or urgent care services, as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

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To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details. Please note that you only have coverage for Emergency and urgent care health care services when traveling outside the United States.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bCBS.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by a BlueCard/Out-of-Network/Non-Participating Provider
Provider	- Member must get Precertification. - If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. - For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Request Categories

- Emergent Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

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- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review**- A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an inpatient admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

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Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective <u>Emergent</u> <u>Urgent</u>	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non- <u>Emergent</u> <u>Urgent</u>	2 business days from the receipt of the request
Continued Stay Review <u>Urgent</u> <u>Emergent</u> when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review <u>Urgent</u> <u>Emergent</u> 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
Continued Stay Review Non- <u>Urgent</u> <u>Emergent</u>	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	
Prospective <u>Urgent</u> <u>Emergent</u>	72 hours from the receipt of request
Prospective Non- <u>Urgent</u> <u>Emergent</u>	15 calendar days from the receipt of the request
Continued Stay Review <u>Urgent</u> <u>Emergent</u> when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review <u>Urgent</u> <u>Emergent</u> 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
Continued Stay Review Non- <u>Urgent</u> <u>Emergent</u>	15 calendar days from the receipt of the request

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If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a ~~covered benefit~~Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary. These programs are given at no extra cost to you.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your ~~chosen~~ authorized representative, treating Doctor(s), and other Providers.

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In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop

providing extended benefits or approving alternate care. In such case, we will notify you or your
| authorized representative in writing.

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What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

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Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A mortuary or funeral home.

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your Plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Comment [tdw3]: Embedded pediatric dental new for this year

Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers

Recent Space Maintainer

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty
- Gingival flap:
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;

- Soft tissue allograft
- Combined connective tissue and double pedicle graft
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recent Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- **Limited Treatment** - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- **Interceptive Treatment** - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- **Comprehensive (complete) Treatment** - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- **Removable Appliance Therapy** - An appliance that is removable and not cemented or bonded to the teeth.
- **Fixed Appliance Therapy** - A component that is cemented or bonded to the teeth.
- **Other Complex Surgical Procedures** - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed

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Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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: (a) place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means 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.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service. When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor does not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis.

Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

See "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** has been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you

coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered **benefits** **Services** for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,

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- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.

- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.

6. Immunoreactive trypsin (IRT).
7. DNA testing.

[Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.]

[Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.]

Abortion Services

Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

~~Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape.~~

Comment [tdw4]: New mandate for 2014

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often.
 - Rehabilitation, therapy, and education.
- ~~• **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation.~~

- ~~Outpatient Services~~ including treatment in an outpatient department of a Hospital and office visits.
- ~~Day Treatment Services~~ which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care" benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in "Urgent Care Services" later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women's contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."]
 - b. Breastfeeding support, supplies, and counseling. [Standard Benefits for breast pumps are limited to [1-10 one] pump per [Standard pregnancy] [Benefit Period].]
 - c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites, [\[http://www.healthcare.gov/center/regulations/prevention.html\]](http://www.healthcare.gov/center/regulations/prevention.html), [\[http://www.ahrq.gov\]](http://www.ahrq.gov), and [http://www.cdc.gov/vaccines/acip/index.html\]](http://www.cdc.gov/vaccines/acip/index.html)

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" later in this Booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:]

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services **All Members/All Ages**" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

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Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and

- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "[Prescription Drugs Administered by a Medical Provider](#)" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than

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30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “[Prescription Drugs Administered by a Medical Provider](#)” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

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Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services For Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In Network.

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating.

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Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglasses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglasses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

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Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

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Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- [Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. Smoking cessation products and

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over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.]

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;

- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs. This tier contains higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1) Abortion Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details. This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a Doctor.

2) Acts of War, Disasters, or Nuclear Accidents In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

3) Administrative Charges

- a) Charges to complete claim forms,
- b) Charges to get medical records or reports,
- c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

4) Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

- a. Acupuncture,
- b. Holistic medicine,
- c. Homeopathic medicine,
- d. Hypnosis,
- e. Aroma therapy,
- f. Massage and massage therapy,
- g. Reiki therapy,
- h. Herbal, vitamin or dietary products or therapies,
- i. Naturopathy,
- j. Thermography,
- k. Orthomolecular therapy,
- l. Contact reflex analysis,
- m. Bioenergetic synchronization technique (BEST),
- n. Iridology-study of the iris,
- o. Auditory integration therapy (AIT),
- p. Colonic irrigation,
- q. Magnetic innervation therapy,
- r. Electromagnetic therapy.

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- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- ~~4)~~
- ~~5)~~ 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- ~~6)~~ 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- ~~7)~~ 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- [Religious group opt out to exclude medical portion of Contraceptive benefit:**
- ~~8)~~ 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- ~~9)~~ 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- ~~10)~~ 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- ~~11)~~ 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence. ~~This Exclusion does not apply if you were the victim of a crime, including domestic violence.~~
- ~~12)~~ 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- 15) Dental Services**
 - a) Dental care for Members age 19 or older.
 - b) Dental services not listed as covered in this Booklet.
 - c) Oral hygiene instructions.
 - d) Case presentations
 - e) Athletic mouth guards, enamel microabrasion and odontoplasty.
 - f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
 - g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
 - h) Pulp vitality tests.
 - i) Adjunctive diagnostic tests.

- i) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- n) Incomplete root canals.
- o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
- p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- q) Provisional splinting, temporary procedures or interim stabilization.
- r) Services of anesthesiologists, unless required by law.
- s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- w) Canal prep & fitting of preformed dowel & post.
- x) Temporary, provisional or interim crown.
- y) Occlusal procedures.
- z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- aa) Pin retention is not covered when billed separately from restoration procedure.
- bb) Services for the replacement of an existing partial denture with a bridge.
- cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- ee) Separate services billed when they are an inherent component of another covered service.
- ff) Cone beam images.
- gg) Anatomical crown exposure.
- hh) Temporary anchorage devices.
- ii) Sinus augmentation.
- jj) Repair or replacement of lost/broken appliances.

13) ~~Dental Treatment~~ Dental treatment, except as listed below.

~~Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:~~

- ~~• Removing, restoring, or replacing teeth;~~
- ~~• Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);~~
- ~~• Services to help dental clinical outcomes.~~

~~Dental treatment for injuries that are a result of biting or chewing is also excluded.~~

~~This Exclusion does not apply to services that we must cover by law.~~

- ~~14)~~**16) Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

- ~~15)~~**17) Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the process and criteria we use to determine if a Service is Experimental or Investigational are outlined below.

- ~~16)~~**18) Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

- ~~17)~~**19) Eye Exercises** Orthoptics and vision therapy.

- ~~18)~~**20) Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

- ~~19)~~**21) Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

- ~~20)~~**22) Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

- Cleaning and soaking the feet.
- Applying skin creams to care for skin tone.
- Other services that are given when there is not an illness, injury or symptom involving the foot.

- ~~21)~~**23) Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.

- ~~22)~~**24) Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

- ~~23)~~**25) Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

- ~~24)~~**26) Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

- | ~~25)~~27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- | ~~26)~~28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- | ~~27)~~29) **Infertility Treatment** Testing or treatment related to infertility.
- | ~~28)~~30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- | ~~29)~~31) **Medical Equipment and Supplies**
 - a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
- | ~~30)~~32) **Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- | ~~31)~~33) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- | ~~32)~~34) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- | ~~33)~~35) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- | ~~34)~~36) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- | ~~35)~~37) **Personal Care and Convenience**
 - a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c) Home workout or therapy equipment, including treadmills and home gyms,
 - d) Pools, whirlpools, spas, or hydrotherapy equipment.
 - e) Hypo-allergenic pillows, mattresses, or waterbeds,
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- | ~~36)~~38) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.

37) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

38) **Providers** Services you get from a non-covered Provider, as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

39) **Residential Treatment Centers** Unless we must cover them by law.

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40) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.

41) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

42) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.

43) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

44) **[Religious group opt out to exclude: Sterilization]** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]

45) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

46) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

47) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

48) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

49) **Vision Services**

- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
- b) Safety glasses and accompanying frames.
- c) For two pairs of glasses in lieu of bifocals.
- d) Plano lenses (lenses that have no refractive power)
- e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
- f) Vision services not listed as covered in this Booklet.
- g) Cosmetic lenses or options.
- h) Blended lenses.
- i) Oversize lenses.
- j) Sunglasses and accompanying frames.
- k) For services or supplies combined with any other offer, coupon or in-store advertisement.
- l) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
- m) Certain frames in which the manufacturer imposes a no discount policy.

50) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover Bariatric Surgery per mandate option This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

- 51) **Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery**
Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgeries that reduce stomach size), or gastric banding procedures].

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **[optional - Clinically-Equivalent Alternatives]** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over its clinically equivalent alternative.}]

3. **Compound Drugs** Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer. ~~Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.~~

[Religious group opt out to exclude Contraceptive drugs:

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.}]
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com.] If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.

9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments.
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
15. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
16. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
18. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

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26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan. Details on the process and criteria your Plan uses to decide if a service is Experimental or Investigational are outlined below.

If you disagree with our denial of a service as Experimental or Investigational, you have the right to file a Grievance with us. Please refer the **Grievance and External Review Procedures** section of this Booklet for more information.

Process to Determine an Experimental or Investigational Service

Our process to decide whether a service is Experimental or Investigational includes medical and technical research of the service, committee review and decision, and final approval by our Chief Medical Officer.

First, our medical policy staff reviews a service based on the criteria listed in the provision below. Information on the service is gathered and combined by our Medical policy staff into a formal evaluation that includes background information, a summary of research findings, and a draft of our formal policy.

Next, the draft of the policy and literature on the service is distributed to the medical policy committee for review and discussion. The committee, which meets four times a year, is made up of a panel of Plan Physicians, most of which are actively practicing In-Network Physicians representing various medical specialties. The committee considers at a minimum the applicable scientific literature and information as required by regulatory organizations. The committee may also ask for input from one or more Physician consultants from a panel of consultants representing a wide range of the subspecialties of medicine.

After reviewing all information related to the service, the committee recommends a final policy. The policy is forwarded to the medical policy committee chairman and Chief Medical Officer for approval.

Our policy on a service is reviewed as appropriate, every three years or less, by our medical policy staff and medical policy committee, with approval of our Chief Medical Officer and medical policy committee chairman.

We also maintain a process for deciding when existing policy on a service calls for added review and change and alerts our medical policy committee of the need to change the existing policy or make a new policy. This may come about as a result of changes in peer-reviewed literature, clinical trials, regulatory status, or other medical information, which could alter or change our position on a current policy or intervention. An interim policy for approval of changes may be used on a limited basis by us to make policy change between regularly scheduled meetings of the medical policy committee.

Criteria to Determine an Experimental or Investigational Service

The criteria we or our designee use when making the determination of whether a Service is Experimental or Investigational when it is rendered for the evaluation or treatment of a disease, injury, illness or condition is outlined below. We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Out-of-Area Services" and "Inter-Plan Programs" later in this section for additional information.

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The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket

responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

When you receive Emergency Care rendered by an Out-of-Network Provider, by law, the Out-of-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total out of pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*
- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of*

\$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.

- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of \$1500, or \$450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is \$500, you may receive a bill from the Out-of-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your In-Network Copayment of \$25, your total out of pocket expense would be \$325.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

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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.

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency and urgent care obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

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, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area Anthem serves, if this Booklet covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Anthem serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Booklet.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When covered healthcare services are provided outside of our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. A Out-of-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 *[(carve-out) Medicare]* 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 generally 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.

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.

"Recovery" means is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Member Your Rights and Responsibilities as an Anthem Blue Cross and Blue Shield Member

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.

- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.
- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

As an Anthem Blue Cross and Blue Shield (Anthem) Member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights" and helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- ~~Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your Plan.~~
- ~~Work with your doctors in making choices about your health care.~~
- ~~Be treated with respect, dignity, and the right to privacy.~~
- ~~Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.~~
- ~~Get information about our company and services, and our network of doctors and other health care Providers.~~
- ~~Get more information about your rights and responsibilities and give us your thoughts and ideas about them.~~
- ~~Give us your thoughts and ideas about any of the rules of your Plan and in the way your Plan works.~~
- ~~Make a complaint or file an appeal about:~~
 - ~~— Your Plan~~
 - ~~— Any care you get~~
 - ~~— Any Covered Service or benefit ruling that your Plan makes.~~
- ~~Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.~~
- ~~Participate in matters that deal with our policies and operations.~~
- ~~Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information that information will be given to someone else that you choose.~~
- ~~Get help at any time, by contacting your local insurance department.~~

You have the responsibility to:

- ~~Choose any Primary Care Physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.~~
- ~~Treat all doctors, health care professionals and staff with courtesy and respect.~~
- ~~Keep all scheduled appointments with your health care Providers and call their office if you have a delay or need to cancel.~~

- ~~Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.~~
- ~~To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.~~
- ~~Follow the care plan that you have agreed on with your doctors or health care professionals.~~
- ~~Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.~~
- ~~Follow all Plan rules and policies.~~
- ~~Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.~~
- ~~Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.~~

~~For details about your coverage and benefits, please read the rest of this Booklet.~~

~~**We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.**~~

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is 1-800-368-3238/1-317-287-5968 if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P.O. Box 1122
Minneapolis, Minnesota
55440-1122]

For "Vision Benefits for Members Through Age 18" Issues:

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 3 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).

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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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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 Booklet.

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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 not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- **The Subscriber's spouse.** For information on spousal eligibility please contact the Group. The Subscriber's spouse as recognized under the laws of the state where the Subscriber lives.
- **[Domestic partner coverage option: This only applies to Groups who have this option:]** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who [Standard when affidavit used] has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for [12 months] or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard when affidavit used:] To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]]
- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

Comment [tdw6]: Check with Sue to ensure she is OK with this for Indiana

- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

~~Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Plan unless required by the laws of this state.~~

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- ~~Subscriber and one child;~~
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during [an Open Enrollment period or during] a Special Enrollment period, as described below.

[Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan [prior to Open Enrollment] if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.
- ~~Lost eligibility under a prior health plan for reasons other than non-payment of premium (or contribution to premium) or due to fraud or intentional misrepresentation of a material fact.~~
- ~~Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.~~
- ~~Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.~~

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- ~~Evidence of prior creditable coverage is required and must be furnished by you or your prior carrier.~~

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they **may apply for coverage at any time during the year as a Late Enrollee.** However, you will not be eligible to enroll until the next Open Enrollment Period.

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Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.
~~No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, or age.~~

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Certification of Prior Creditable Coverage

~~If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another Group health plan.~~

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u>	
Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
<u>For Dependents:</u>	
A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

If we terminate the Group Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, we will continue your coverage for Inpatient Covered Services. Coverage will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after the Group Contract terminated;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by us;
- The Premium is not paid within the grace period shown in the Group Contract.

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or

3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Corporate Structure

The Plan is an Indiana domiciled insurance corporation owned by its stockholders and directed by a board of directors, who provide general leadership to the Plan. It is managed by a team of officers who receive direction from the board of directors and in turn direct the operations of the Plan. The Plan consists of a number of operational divisions including, but not limited to: Operations, Medical Management, Network Development, Marketing, Claims Administration, Risk Management, Legal and Member Services.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled.

You should enroll in Medicare Part B as soon as possible to avoid potential liability.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing

eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.]

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives

such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.) We may offer health or fitness related program options for purchase by your Group. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed and could be discontinued at any time. If your Group has selected one of these options, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors when administered according to state or federal law. However, if it is unreasonably difficult due to a medical condition for you to achieve the standards for a reward under such a program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive gift cards and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

-Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "Benefits After Termination."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Medical technology or a new application of existing medical technology, including medical procedures, Drugs, and devices for treating a medical condition, illness, or diagnosis that:

- is not generally accepted by informed health care professionals in the United States as effective; or

- has not been proven by scientific testing or evidence to be effective;

in treating the medical condition, illness, or diagnosis for which its use is proposed.

For how this is determined, see the "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "~~Eligibility and Enrollment – Adding Members~~~~Eligibility and Enrollment – Adding Members~~" section for further details.

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Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

~~_____The most you pay during a Benefit Period for Covered Services before your Plan begins benefits. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Schedule of Benefits" for details.~~

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Predetermination

Please see the section "Getting Approval for Benefits " for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 1) ~~Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.~~
- 2) Insulin, diabetic supplies, and syringes.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

~~A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Covered Providers are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.~~

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider as approved by state regulatory agencies.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

1/2015

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

Anthem [Preferred] [Essential] [Core] [Gold] [Silver] [Bronze] Direct
Blue Access PPO [Copayment or Deductible/ Coinsurance/ Out-of-
Pocket Limits] [Plus] [w/ HSA]
[w/Dental] [/] [Vision] [w/HRA] [/HSA]



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Customer Service at the number on the back of your Identification Card.

Anthem Insurance Companies, Inc.

[120 Monument Circle]
[Indianapolis, Indiana 46204]

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, ~~provided that you request enrollment within 31 days after your other coverage ends~~ if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Customer Service telephone number on your Identification Card, or contact the Group.

[Standard, but can remove if a group is not subject to ERISA:

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.]

Notices Required by State Law

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

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Customer Service at the number on the back of your Identification Card. Also be sure to check our website, [www.anthem.com] for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

[Use with HSAs:

High-Deductible Health Plan for Use with Health Savings Accounts

This Plan is meant to be federally tax qualified and used with a qualified health savings account. Approval by the **Indiana Department of Insurance** does not guarantee tax qualification and this Plan has not been submitted for approval by the IRS. Please seek the advice of a tax advisor.]

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

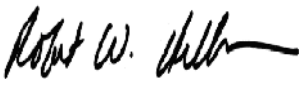

[President]

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	[Calendar Year] [Plan Year]
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment- Adding Members" section for further details

Deductible	In-Network	Out-of-Network
Per Member	[\$0-\$6,400] [\$1,000-\$6,300]	[\$1,000-\$12,000] [\$2,000-\$12,600]
Per Family [Aggregate/ Delete for non-embedded CDHP plans: All other Members combined]	[\$0-\$12,800] [\$2,000-\$12,600]	[\$3,000-\$24,000] [\$4,000-\$25,200]
[Option for Non-Embedded Plans (CDHP): If you, the Subscriber, are the only person covered by this Plan, only the “per Member” amounts apply to you. If you also cover Dependents (other family members) under this Plan, only the “per Family” amounts apply.]) The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible. [Option HRA funds cannot be used for services listed under “Dental Services for Members Age 19 and Older” or for services listed under “Vision Services for Members Age 19 and Older.”] [Deductible First HRA: Note: To meet the In-Network Deductible, your Plan will work as follows: Step 1 – Upfront In-Network Deductible — Members must pay a certain part of the In-Network Deductible listed above, [\$750-\$3,000] per Member [and] [\$1,500-\$6,000] per Family], before using their HRA account. HRA funds cannot be used for this part of the Deductible (known as the “upfront” Deductible). Amounts paid toward the upfront Deductible will apply toward the annual In-Network Deductible. Step 2 – Health Reimbursement Account — After meeting the upfront Deductible, Members can use money in their HRA to help meet the rest of the annual In-Network Deductible. Step 3 – Traditional Health Coverage — Once the Annual In-Network Deductible has been met, coverage under this Plan begins.]		

Coinsurance	In-Network	Out-of-Network
Plan Pays	[100%-50%]	[70%-50%]
Member Pays	[0%-50%]	[30%-50%]
Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount. Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.		

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	[\$2,000- \$6,350] \$6,600]	[\$4,000- \$12,700] \$4,500- \$15,750]
Per Family [Aggregate/ Delete for non-embedded CDHP plans: All other Members combined]	[\$4,000- \$12,700] \$13,200]	[\$8,000- \$25,400 \$9,000- \$31,500]
[Option for Non-Embedded Plans: If you, the Subscriber, are the only person covered by this Plan, only the "per Member" amounts apply to you. If you also cover Dependents (other family members) under this Plan, only the "per Family" amounts apply.] [Standard for plans with deductible, coinsurance and copays: The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.] [For plans that have deductible & coinsurance only, without copays: The Out-of-Pocket Limit includes all Deductibles and Coinsurance you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.] The Out-of-Pocket Limit does not include amounts you pay for following benefits: • [Standard Option for embedded adult dental benefit / Do not use for HRA/HSA: Services listed under "Dental Services for Members Age 19 and Older"] • [Option for embedded adult vision benefit / Do not use for HRA/HSA: Services listed under "Vision Services for Members Age 19 and Older"] • Out-of-Network Human Organ and Tissue Transplant services. Once the Out-of- Pocket Limit is satisfied, you will not have to pay any additional [Use for plans with deductible, coinsurance and copays: Deductibles, Coinsurance, or Copayments] [Use for plans with deductible and coinsurance only: Deductibles or Coinsurance] for the rest of the Benefit Period [, except for the services listed above]. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water)	[\$100 Copayment] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Ambulance Services (Ground)	[\$100 Copayment] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	See "Mental Health and Substance Abuse Services."	
Cardiac Rehabilitation	See "Therapy Services."	
Chemotherapy	See "Therapy Services."	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services for Members Through Age 18		
Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• Diagnostic and Preventive Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Basic Restorative Services	40% Coinsurance after Deductible	50% Coinsurance after Deductible
• Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Periodontal Services - Oral Surgery Services - Major Restorative Services - Prosthodontic Services - Dentally Necessary Orthodontic Care - Dentally Necessary Orthodontic Care Waiting Period	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 12 months
[Optional – Embedded Adult Dental: Dental Services for Members Age 19 and Older Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
Each Member must pay a Deductible of \$50 per Benefit Period for the dental services below. [2014 Option: This Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan.]		
Diagnostic and Preventive Services	0% Coinsurance	50% Coinsurance
Basic Restorative Services	20% Coinsurance	60% Coinsurance
Endodontic Services	50% Coinsurance	75% Coinsurance
Periodontal Services	50% Coinsurance	75% Coinsurance
Oral Surgery Services	50% Coinsurance	75% Coinsurance
- Major Restorative Services - Prosthodontic Services	50% Coinsurance 50% Coinsurance	75% Coinsurance 75% Coinsurance
Orthodontic Care	Not Covered	Not Covered
Dental Services for Members Age 19 and Older Benefit Maximum	\$1,000 per Benefit Period In- and Out-of-Network combined)	
Dental Services (All Members / All Ages) Benefits are based on the setting in which Covered Services are received. Dental Services Accidental Injury Benefit Maximum \$3,000 per Accidental Injury, In- and Out-of-Network combined Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that We are required to cover by law.		

Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Wigs Needed After Cancer Treatment Benefit Maximum The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received. 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, and Copayment as any other service under this Plan.	One wig per Benefit Period, In- and Out-of-Network combined	
Emergency Room Services		
Emergency Room		
Emergency Room Facility Charge	[\$200- \$250] Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible] [Copayment waived if admitted]	
Emergency Room Doctor Charge	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		
Home Care		

Benefits	In-Network	Out-of-Network
Home Care Visits	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Dialysis	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Infusion Therapy	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Specialty Prescription Drugs	[\$10- \$50] Copayment] [per Drug] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Home Care Services / Supplies	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period, In- and Out-of-Network combined. The limit does not apply to Home Infusion Therapy or Home Dialysis.	
Private Duty Nursing Benefit Maximum	82 visits per Benefit Period, In- and Out-of-Network combined 164 visits per Lifetime, In- and Out-of-Network combined	
Home Infusion Therapy	See "Home Care."	
Hospice Care		
- Home Care - Respite Hospital Stays	[No Copayment, Deductible, or Coinsurance] [0% Coinsurance] [no Deductible] [after Deductible]	[0%-50%] Coinsurance after Deductible
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services		
Please see the separate summary later in this section.		
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	[\$250 - \$1,500] Copayment [per admission] [plus] [0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors:]		
Note: If you use a Preferred Hospital / Acute Care Facility you will pay fa [\$125 - \$1,250] Copayment [per admission] [plus] [0%-40%] Coinsurance [no Deductible] [after Deductible]. [Please see [anthem.com] for a list of Preferred Facilities.]]		
Skilled Nursing Facility	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors:]		
Note: If you use a Preferred Skilled Nursing Facility you will pay [0%- 40%] Coinsurance [no Deductible] [after Deductible]. [Please see [anthem.com] for a list of Preferred Facilities.]]		
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period, In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[For plans with hospital copay:]		
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.]		
[For plans with hospital copay:]		
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.]		
Doctor Services for:		
General Medical Care / Evaluation and Management (E&M)	[0%-50%] Coinsurance [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Surgery	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Maternity and Reproductive Health Services		
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal and delivery services)	[\$10- \$50] Copayment] [per pregnancy] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
<i>[Use only when copays apply:</i> If you change Doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.]	<i>[Use only when OV copay applies:</i> The Office Visit Copayment will also apply to the first prenatal visit.]	
Inpatient Services (Delivery)	See "Inpatient Services"	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Abuse Services		
Inpatient Facility Services	[\$250- \$1,500] Copayment] [per admission] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Inpatient Facility you will pay a [\$125- \$750] Copayment] per admission [plus] [0%- 50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Inpatient Doctor Services	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Outpatient Facility Services	[\$250 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [after Deductible] [no Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [a \$125 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
Outpatient Doctor Services	[0%- 50%] Coinsurance] [No Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	[\$250 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendor Plans: Note: If you use a Preferred Partial Hospital/ Intensive Outpatient Facility you will pay [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Providers.]]		
Office Visits	[Covered in PCP / SCP Copayment] [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Mental Health and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.		
Occupational Therapy		See "Therapy Services."
Office Visits		
Primary Care Physician / Provider (PCP)	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[PC2: Note: If your PCP is part of our Patient-Centered Primary Enhanced Personal Health Care Program you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible].]		

Benefits	In-Network	Out-of-Network
Specialty Care Physician / Provider (SCP)	[\$20- \$60 \$75] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Retail Health Clinic Visit	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Retail Health Clinic you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Clinics.]]		
Online Visit	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Online Visit Provider you will pay [a [\$5- \$25] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Providers.]]		
Nutritional Counseling- includes Family Planning and Nutritional Counseling (Other than Eating Disorders)	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Nutritional Counseling for Eating Disorders	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Allergy Testing	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Allergy Shots/Injections (other than allergy serum)	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic Lab (non-preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic X-ray (non-preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic Tests (non-preventive; including hearing and EKG)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Office Surgery	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Therapy Services:		
- Chiropractic Care & Spinal Manipulation	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
- Physical, Speech, & Occupational Therapy	[\$10- \$50] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Dialysis / Hemodialysis	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
- Cardiac Rehabilitation & Pulmonary Therapy	[\$20- \$60 \$75] Copayment] [per visit] [for the first 3 visits, then] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (includes allergy serum)	[\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Optional if 3 visits apply: Several services listed above have a Copayment for the first three visits. This Copayment applies to any combination of services for the first three visits during the Benefit Period. Starting with the fourth visit, you pay Deductible and Coinsurance, instead of a Copayment. The three Copayments will not apply to Preventive Care, Maternity Services, or Urgent Care visits. You will not have to pay any Deductible or Coinsurance when you pay the Copayment.]		
Orthotics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	
Outpatient Facility Services		
• Facility Surgery Charge	[\$250 Copayment] [per visit] [plus] [0%- 50%] Coinsurance] [after Deductible] [no Deductible]]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [\$125 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
• Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Doctor Surgery Charges	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Other Facility Charges (for procedure rooms or other ancillary services)	[\$250 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [\$125 Copayment] [per visit] [plus] [0%-50%] Coinsurance] [no Deductible] [after Deductible]. [Please see anthem.com for a list of Preferred Facilities.]]		
• Diagnostic Lab	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic X-ray	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	[\$250 Copayment] [per service] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
[Preferred Vendors: Note: If you use a Preferred Outpatient Facility you will pay [\$125 Copayment] [per service] [0%-50%] Coinsurance] [no Deductible] [after Deductible] for advanced diagnostic imaging services. [Please see anthem.com for a list of Preferred Facilities.]]		

Benefits	In-Network	Out-of-Network
- Therapy: - Chiropractic Care & Spinal Manipulation [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] - Physical, Speech, & Occupational Therapy [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] - Radiation / Chemotherapy / Non-Preventive Infusion & Injection [0%-50%] Coinsurance] [no Deductible] [after Deductible] - Dialysis / Hemodialysis [0%-50%] Coinsurance] [no Deductible] [after Deductible] - Cardiac Rehabilitation & Pulmonary Therapy [\$20- \$60 \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible] See "Therapy Services" for details on Benefit Maximums. - Prescription Drugs Administered in an Outpatient Facility [\$10- \$50] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]		
Physical Therapy	See "Therapy Services."	
Preventive Care	No Copayment, Deductible, or Coinsurance	[30%-50%] Coinsurance after Deductible
Prosthetics	See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies."	

Benefits	In-Network	Out-of-Network
Pulmonary Therapy	See "Therapy Services."	
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See "Therapy Services."	
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	See "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received.	
• [optional offer mandate – add when selected –Bariatric Surgery	Benefits are based on the setting in which Covered Services are received limited to a Benefit Maximum of \$10,000 per Lifetime, In- and Out-of-Network combined]	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
• Physical Therapy	20 visits per Benefit Period	
• Occupational Therapy	20 visits per Benefit Period	
• Speech Therapy	20 visits per Benefit Period	
• Manipulation Therapy	20 visits per Benefit Period	
• Cardiac Rehabilitation	36 visits per Benefit Period	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		

Benefits	In-Network	Out-of-Network
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	
Urgent Care Services (Office Visits)		
Urgent Care Office Visit Charge	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Testing	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Allergy Shots/ Injections (other than allergy serum)	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	[0%- 50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	[0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Office Surgery	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	[\$35- \$75] Copayment] [per visit] [0%-50%] Coinsurance] [no Deductible] [after Deductible]	[30%-50%] Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		
Vision Services for Members Through Age 18 Note: To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam	\$0 Copayment	Covered up to \$30
Limited to one exam per Benefit Period		
Standard Plastic Lenses		
Limited to one set of lenses per Benefit Period every other calendar year. Available only if the contact lenses benefit is not used.		
Single Vision	\$0 Copayment	Covered up to \$25
Bifocal	\$0 Copayment	Covered up to \$40
Trifocal	\$0 Copayment	Covered up to \$55
Progressive	\$0 Copayment	Covered up to \$40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost In-Network.		
Frames	\$0 Copayment	Covered up to \$45
Limited to one set of frames from the Anthem Formulary per Benefit Period every other calendar year.		
Contact Lenses		
Limited to one set of contact lenses from the Anthem formulary per Benefit Period every other calendar year. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	\$0 Copayment	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Optional / Adult Embedded Vision Exam Plus Materials:		
Vision Services for Members Age 19 and Older		
Note: To get the In-Network benefit, you must use		

Benefits	In-Network	Out-of-Network
an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam Limited to one exam per Benefit Period.	\$20 Copayment	Covered up to \$30
Standard Plastic Lenses Limited to one set of lenses [per Benefit Period] [every other calendar year]. Available only if the contact lenses benefit is not used.		
Single Vision	\$20 Copayment	Covered up to \$25
Bifocal	\$20 Copayment	Covered up to \$40
Trifocal	\$20 Copayment	Covered up to \$55
Note: In-Network, lenses include factory scratch coating at no additional cost.		
Frames Limited to one set of frames [per Benefit Period] [every other calendar year].	Covered up to \$130	Covered up to \$45
Contact Lenses Limited to one set of contact lenses [per Benefit Period] [every other calendar year]. Available only if the eyeglass lenses benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	Covered up to \$80	Covered up to \$60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to \$210
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		
Benefits are based on the setting in which Covered Services are received.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services Please call our Transplant Department as soon you think you may need a transplant to talk about your benefit options. You must do this <i>before</i> you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from a Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Customer Service, ask for the Transplant Case Manager for further details.)		

Benefits	In-Network	Out-of-Network
The requirements described below do not apply to the following: • Cornea and kidney transplants, which are covered as any other surgery; and • Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service. Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.		
Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider
	Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility
• Precertification required	During the Transplant Benefit Period, [no Copayment / Deductible / Coinsurance.] [\$250-\$1,500 Copayment] [per admission] [0% - 50% Coinsurance] [after Deductible] Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services,	During the Transplant Benefit Period, You will pay [30% -50%] Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also

Benefits	In-Network	Out-of-Network
	Home Visits, or Office Visits depending where the service is performed.	an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
	[No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30%-50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	[Standard: No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.] [Option: Not covered]

Benefits	In-Network	Out-of-Network
Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant In- and Out-of-Network combined.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	[Standard: No Copayment / Deductible / Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant, In- and Out-of-Network combined.	
Live Donor Health Services	[Standard: No Copayment/ Deductible/ Coinsurance] [0% - 50%] Coinsurance after Deductible]	[30% - 50%] Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. [Standard, but may remove for HRA/HSA plans that don't have copays: You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.] [Optional for Plans w/ Rx Deductible: Prescription Drug Deductible (Does not apply to Tier 1) [Per Member] [\$250-\$500] In- and Out-of-Network combined] [Per Family] [\$500- \$1,000] In- and Out-of-Network combined] [2014 Option: Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments/Coinsurance listed below.]		
[Optional for Plans w/ Rx OOP Limit: Prescription Drug Out of Pocket Limit [Per Member] [\$6,350 In- and Out of Network combined] [Per Family] [\$12,700 In- and Out of Network combined]		

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
[2014 Option: Note: The Prescription Drug Out of Pocket Limit is separate and does not apply toward any other Out of Pocket Limit for Covered Services in this Plan. It includes all Deductibles, Coinsurance, and Copayments you pay for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy during a Benefit Period. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.]		
[2014 Option if Separate Rx OOP: Once the Out of Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy for the rest of the Benefit Period.]		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)		30 days
Home Delivery (Mail Order) Pharmacy		90 days
Specialty Pharmacy (In-Network and Out-of-Network)		30 days*
	*See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
[Use for HSA Plans: Note: The Prescription Drug Copayments listed below will not apply until after the Plan Deductible is met.]		
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$10- \$15] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 2 Prescription Drugs	[\$30- \$50] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 3 Prescription Drugs	[\$60- \$90] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Tier 4 Prescription Drugs	[0%-50%] Coinsurance [to a maximum of \$250- \$500] [after Deductible] per Prescription Drug	50% Coinsurance [after Deductible] per Prescription Drug
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	[\$25- \$38] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 2 Prescription Drugs	[\$75- \$125] Copayment [0%-50%] Coinsurance [after Deductible] per Prescription Drug	Not covered
Tier 3 Prescription Drugs	[\$150- \$225] Copayment] [0%-50%] Coinsurance] [after Deductible] per Prescription Drug	Not covered
Tier 4 Prescription Drugs	[0%-50%] Coinsurance] [to a maximum of [\$250- \$500] [after Deductible] per Prescription Drug	Not covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.		
[OPTIONAL-Brand Penalty: Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. [If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug.] By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.] [Regular PPO plans: Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.] [HSA plans: Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.]		
Orally Administered Cancer Chemotherapy	[Use with all regular plans: No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network. No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-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.]	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
	[Use with HSA RX copay plans: After Deductible has been satisfied, no Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network. After Deductible has been satisfied, you get from an Out-of-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.] [Use with HSA coinsurance plans: Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from an In-Network Pharmacy, Home Delivery Pharmacy, Specialty Pharmacy Network, or Non-Network Pharmacy.] 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.	

How Your Plan Works

Introduction

Your Plan is a PPO plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Customer Service before you get services for more information.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

[PC2 option:

~~Patient-Centered Primary Care~~Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our ~~Patient-Centered Primary Care~~ Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.]

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

Crediting Prior Plan Coverage

If you were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Group offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- **Your Group moves to this Plan at the beginning of a Benefit Period;**
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard® Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard®." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need health care, as long as you use a BlueCard® Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

In a non-Emergency situation, you can find the nearest contracted Provider by visiting the BlueCard® Doctor and Hospital Finder website [www.BCBS.com] or call the number on the back of your Identification Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard® program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard® Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard® Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at [(800) 810-BLUE (2583)] or by calling collect at [(804) 673-1177]. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard® Worldwide.

Payment Details

- **Participating BlueCard® Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard® Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard® Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard® Worldwide Service Center. Then you can fill out a BlueCard® Worldwide claim form and send it with the original bill(s) to the BlueCard® Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard® Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard® Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard® Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by a BlueCard®/Out-of-Network/Non-Participating Provider
Provider	- Member must get Precertification. - If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. - For an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by contacting the Customer Service number on the back of your ID card.

[2015 Update for Fraud & Balance Billing Program per Legal: We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.]

Request Categories

- **Emergent Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review**- A request for Precertification or Predetermination that is conducted during the course of **outpatient** treatment or **during an Inpatient** admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective Emergent/Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non- Emergent/Urgent	2 business days from the receipt of the request
Continued Stay Review Emergent/Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent/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
Continued Stay Review Non- Emergent/Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	
Prospective Emergent/Urgent	72 hours from the receipt of request
Prospective Non- Emergent/Urgent	15 calendar days from the receipt of the request
Continued Stay Review Emergent/Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request

Continued Stay Review Emergent-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
Continued Stay Review Non- Emergent-Urgent	15 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed.

For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be a **covered benefit/Covered Service** under your Plan;
4. The service cannot be subject to an Exclusion under your Plan; and
5. You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management **Program program** to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving. **These programs are given at no extra cost to you.**

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your **chosen authorized** representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your **authorized** representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for more important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- a) A Doctor's office or clinic;
- b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum 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 Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

See “Mental Health and Substance Abuse Services” later in this section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

- i. The Investigational item, device, or service, itself; or
- ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

~~Option—Embedded Dental (Pediatric &/or Adult):~~ Dental Services

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this plan. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your plan. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsurance or deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

~~This Plan covers a preset schedule of dental services without a review for Medical Necessity. [Ortho/Dental Necessity Option: When orthodontic care is covered by this Plan, claims will be reviewed to determine if it was Dentally Necessary orthodontic care. See the “Orthodontic Care” benefit for more information.]~~

~~Your dentist may recommend dental care services that are not covered, are cosmetic in nature, or exceed the benefit maximums of this Plan. While these services may be Medically Necessary for your condition, they may not be covered by this Plan. There may be other dental services available that are covered. These other services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the dental service recommended by your dentist. You will have to pay for any costs that exceed the allowance, in addition to any Deductible, Copayments, or Coinsurance you may have.~~

~~The decision as to what dental care treatment is best for you is solely between you and your dentist.~~

Pretreatment Estimate

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the plan benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the plan may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedure codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

A pretreatment estimate is a valuable tool for you and your dentist. It gives you and the dentist an idea of what your out of pocket costs will be. This allows you and your dentist to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but not required, for you to get benefits for Covered Services.

A pretreatment estimate does not authorize treatment or determine its Medical or Dental Necessity **[Ortho / Dental Necessity option: (except for orthodontics)]**, and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is sent to us. This is an estimate only. Our final payment will be based on the claim that is sent to us at the time of the completed dental care service(s). Sending in other claims or changes to your eligibility or to this Plan may affect our final payment.

You can ask your dentist to send in a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can give these to you). Pretreatment estimate requests can be sent to Anthem Blue Cross and Blue Shield. If you have questions on where to send the estimate, call us at the number on the back of your ID card.

[Option – Embedded Pediatric Dental: Dental Services For Members Through Age 18

This Plan covers the dental services below for Members through age 18 when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, the Plan will cover the least expensive treatment.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s) – 4 single x-rays per 12-month period.
- Occlusal – 2 series per 24-month period.
- Vertical- Covered at 1 series (7 to 8) of bitewings per 6 month period.

Interpretation of diagnostic images by a practitioner not associated with capture of the image, including report.

Dental Cleaning (Prophylaxis)- Any combination of this procedure or periodontal maintenance (see “Periodontal Services” below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per 12-month period calendar year.

Fluoride Varnish Covered 2 times per 12-month period calendar year.

Sealants or Preventive Resin Restorations Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Emergency Treatment for the temporary relief of pain or infection.

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Benefits for amalgam or composite restorations will be limited to one service per tooth per 24-month period.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth)- Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention- per tooth, in addition to restoration.

Space Maintainers Covered once per lifetime for extracted primary posterior (back) teeth.

Recement Space Maintainer

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy– Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy- If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

All of the above endodontic services are limited to once per tooth per lifetime.

Other Endodontic Treatments Limited to once per tooth per lifetime:

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal)- not including root canal therapy
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per calendar year 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement. ~~is covered once per lifetime.~~

Crown Lengthening ~~Covered once per lifetime.~~

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single tooth, or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.
- ~~Only one complex surgical periodontal service is covered per 36-month period for multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.~~

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures ~~Covered only when required to prepare for dentures and limited to once in a 60-month period.~~

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision ~~or of~~ pericoronal gingiva

- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia ~~Covered only when given with covered complex surgical services.~~

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

~~Pre-fabricated or Stainless Steel Crown Covered once per 60-month period.~~

Onlays and/or Permanent Crowns Covered once every ~~5 years~~60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recent Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair ~~Covered once per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.~~ Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every ~~5 years~~60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

~~Resin Infiltration/smooth surface~~

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning ~~Covered once per 24-month period.~~

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered ~~once per 12-month period~~ when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

| **Denture Adjustments** Covered ~~2 times per 12-month period~~ when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

| **Partial and Bridge Adjustments** Covered ~~2 times per 24-month period~~ when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

| **Removable Prosthetic Services (Dentures and Partials)** Covered once ~~per 5-year period~~ every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

| **Fixed Prosthetic Services (Bridge)** Covered once every ~~5 years~~ 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

| **Recent Fixed Prosthetic** ~~Covered once per 12 months.~~

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. **[Ortho / Dental Necessity option:** We will only cover Dentally Necessary orthodontic care. To be considered Dentally Necessary at least one of the following must be present:

- a. There is spacing between adjacent teeth which interferes with the biting function;
- b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
- c. Positioning of the jaws or teeth impair chewing or biting function;
- d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or

Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.}]

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum

Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.†

Optional embedded adult dental benefit: Dental Services For Members Age 19 and Older

This Plan covers the dental services below for Members age 19 and older when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, the Plan will cover the least expensive treatment.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- Bitewings – 1 series per 24-month period.
- Full Mouth (Complete Series) or Panoramic – Once per 60-month period.
- Periapical(s) – 4 single x-rays per 12-month period.
- Occlusal – 2 series per 24-month period.

Dental Cleaning (Prophylaxis) Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth. Any combination of this procedure and periodontal maintenance (See “Periodontal Services” below) are covered 2 times per calendar year.

Basic Restorative Services

Emergency Treatment Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- Anterior (front) Teeth – Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior (back) Teeth – Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Benefits will be limited to the same surfaces and allowances for amalgam (silver filling). You must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and the optional treatment plus any Deductible and/or Coinsurance.

Benefits for amalgam or composite restorations will be limited to one service per tooth surface per 24-month period.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Brush Biopsy—Covered once per 36-month period for Members age 20 to 39. Covered once per 12-month period for Members age 40 and older.

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy
- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

All of the above endodontic services are limited to once per tooth per lifetime.

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 2 times per calendar year.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered once per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- Full mouth debridement is covered once per lifetime.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge—Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single tooth; or
- Only one complex surgical periodontal service is covered per 36-month period for multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removals of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures Covered only when required to prepare for dentures and limited to once in a 60-month period:

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis per site
- Surgical reduction of osseous tuberosity

Surgical Reduction of Fibrous Tuberosity Covered once every 6 months.

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia—Covered only when given with covered complex surgical services. Benefits are not available when given with non-surgical dental care.

Major Restorative Services

Gold foil restorations The Plan will cover an amalgam (silver filling) benefit equal to the same number of surfaces and allowances.

You must pay the difference in cost between the Maximum Allowed Amount for the Covered Services and optional treatment plus any Deductible and/or Coinsurance that applies. Covered once per 24-month period.

Inlays Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 7 years if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance that applies.

Implant Crowns See "Prosthetic Services".

Recent Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered once per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 7 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prosthodontic Services

Tissue Conditioning Covered once per 24-month period.

Reline and Rebase Covered once per 24-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered once per 6-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered 2 times per 12-month period when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered 2 times per 24-month period when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once per 7-year period:

- For the replacement of extracted (removed) permanent teeth;
- If 7 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 7 years:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 7 years;
- If 7 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. — Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic Covered once per 12 months.

Single Tooth Implant Body, Abutment and Crown Covered once per 7 year period. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers 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, 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).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self-management training if you have 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.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

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.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- 1) Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;

- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.

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:

- 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
- 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 as other Covered Services under your Plan.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means 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 layperson who possesses an average knowledge of health and medicine to: (a) place an individual's health in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c) result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means 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.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, but you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover it as an Authorized Service.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by a designee. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** has been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department to as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

| Non-Covered **benefits Services** for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.

- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.
 6. Immunoreactive trypsin (IRT).
 7. DNA testing.

[Optional: Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.]

[Optional: Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the “Preventive Care” benefit.]

Abortion Services

~~Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape. [Standard: The Plan will also cover elective abortions.]~~ Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification, and rehabilitation.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital and office visits or outpatient Facility, such as partial hospitalization and intensive outpatient programs.
- **Day Treatment Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care" benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care as described in “Urgent Care Services” later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs Administered in the Office

Orthotics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the “Diagnostic Services” benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:

- a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
 3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
 4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. [Women's contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."]
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per [Standard: pregnancy] [Benefit Period].
 - c. Gestational diabetes screening.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites,

<http://www.healthcare.gov/center/regulations/prevention.html#what-are-my-preventive-care-benefits>, <http://www.ahrq.gov/clinic/uspstfix.htm>, and <http://www.cdc.gov/vaccines/acip/index.html#recs/acip/>.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state 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.

Prosthetics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" later in this booklet.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;

- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

[Mandated-Optional benefit – add only when selected:

Bariatric Surgery

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.]

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services (All Members/All Ages)" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

~~Include when embedded pediatric dental benefit is included.~~ Your Plan also covers certain oral surgeries for children. Please refer to “Dental Services for Members Through Age 18” for details.†

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person’s ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person’s job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

See “Human Organ and Tissue Transplant” earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Vision Services for Members Through Age 18

The vision benefits described in this section only apply to Members through age 18.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating, UV coating, polycarbonate and photochromic lenses when received In-Network.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:
 - Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This Plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglass lenses until the next Benefit Period. If you choose eyeglass lenses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Optional / Embedded Adult Coverage: Vision Services for Members Age 19 and Older

The vision benefits described in this section only apply to Members age 19 or older.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Lens benefits include factory scratch coating.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)

Frames

A selection of frames is covered under this Plan. Members will get a benefit allowance toward the purchase of any frame. If the frame you choose costs more than the Plan's allowance, you will have to pay the amount over the Plan's allowance.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses — Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses — Only for the following medical conditions:

- Keratoconus when your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses;
- High Astigmatism exceeding -12D or +9D in spherical equivalent;
- Anisometropia of 3D or more;
- When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best-corrected standard spectacle lenses;

Special Note: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

~~This Plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglass lenses until the next Benefit Period. If you choose eyeglasses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.~~

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- **[Standard unless opt out allowed due to religious beliefs:** Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.]
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes 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.
- Flu Shots (including administration). **These products will be covered under the "Preventive Care" benefit.**
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.

- FDA approved smoking cessation products including over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.

Where You Can Get Prescription Drugs

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Customer Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;

- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs. This tier contains higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected “once daily dosage” Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a “½ tablet daily.” The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

[Standard for all plans except HRA/HSA: Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.】

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Abortion** Services, supplies, Prescription Drugs, and other care for ~~option-~~elective (voluntary) abortions and/or fetal reduction surgery. **This Exclusion does not apply to abortions covered under the "Maternity and Reproductive Health Services" benefit. Please see that section for further details.**

~~This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a Doctor.~~

- 2) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

3) **Administrative Charges**

- a) Charges to complete claim forms,
- b) Charges to get medical records or reports,
- c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

- a. Acupuncture,
- b. Holistic medicine,
- c. Homeopathic medicine,
- d. Hypnosis,
- e. Aroma therapy,
- f. Massage and massage therapy,
- g. Reiki therapy,
- h. Herbal, vitamin or dietary products or therapies,
- i. Naturopathy,
- j. Thermography,
- k. Orthomolecular therapy,
- l. Contact reflex analysis,
- m. Bioenergetic synchronization technique (BEST),
- n. Iridology-study of the iris,
- o. Auditory integration therapy (AIT),
- p. Colonic irrigation,
- q. Magnetic innervation therapy,
- r. Electromagnetic therapy.

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Certain Providers** ~~Services you get from a non-covered Provider, as defined in this Booklet.~~ Service you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- 7) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 8) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 9) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

[Religious group opt out to exclude medical portion of Contraceptive benefit:

- 10) **Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]
- 11) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
- 12) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 13) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. ~~This Exclusion does not apply if you were the victim of a crime, including domestic violence.~~ This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- 14) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

[Include when pediatric and/or adult dental benefit is embedded in plan:

15) Dental Services

- a) Dental care for Members age 19 or older.
- b) Dental services not listed as covered in this Booklet.
- c) Oral hygiene instructions.
- d) Case presentations.
- e) Athletic mouth guards, enamel microabrasion and odontoplasty.
- f) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- g) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- h) Pulp vitality tests.
- i) Adjunctive diagnostic tests.

- j) Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- l) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- m) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- n) Incomplete root canals.
- o) Bacteriologic tests for determination of periodontal disease or pathologic agents.
- p) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- q) Provisional splinting, temporary procedures or interim stabilization.
- r) Services of anesthesiologists, unless required by law.
- s) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- t) Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- u) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- v) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- w) Canal prep & fitting of preformed dowel & post.
- x) Temporary, provisional or interim crown.
- y) Occlusal procedures.
- z) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- aa) Pin retention is not covered when billed separately from restoration procedure.
- bb) Services for the replacement of an existing partial denture with a bridge.
- cc) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- dd) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- ee) Separate services billed when they are an inherent component of another covered service.
- ff) Cone beam images.
- gg) Anatomical crown exposure.
- hh) Temporary anchorage devices.
- ii) Sinus augmentation.
- jj) Repair or replacement of lost/broken appliances.

†Include for adult dental embedded coverage:

~~kk) Any material grafted onto bone or soft tissue, including procedures necessary to guided tissue regeneration.~~

~~ll) Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a covered person under this Plan. This Exclusion will not apply for any Member who has been continuously covered for more than 24 months.~~

~~mm) For Members age 19 and older, corrections of congenital conditions during the first 24 months of continuous coverage under this Plan.~~

~~nn) Dental implant maintenance or repair to an implant or implant abutment.~~

~~oo) Orthodontic care for Members age 19 and older.]]~~

[Delete when pediatric and/or adult dental benefit is embedded in plan:

16) Dental Treatment Dental treatment, except as listed below.

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;
- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded.

This Exclusion does not apply to services that we must cover by law.]

~~17)~~ **16) Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

~~18)~~ **17) Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational. Details on the criteria we use to determine if a Service is Experimental or Investigational is outlined below.

~~19)~~ **18) Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

~~20)~~ **19) Eye Exercises** Orthoptics and vision therapy.

~~21)~~ **20) Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

~~22)~~ **21) Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

~~23)~~ **22) Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

- a) Cleaning and soaking the feet.
- b) Applying skin creams to care for skin tone.
- c) Other services that are given when there is not an illness, injury or symptom involving the foot.

~~24)~~ **23) Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.

- | ~~25~~24) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- | ~~26~~25) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers' Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- | ~~27~~26) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- | ~~28~~27) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- | ~~29~~28) **Home Care**
 - a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
 - b) Food, housing, homemaker services and home delivered meals.
- | ~~30~~29) **Infertility Treatment** Testing or treatment related to infertility.
- | ~~31~~30) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- | ~~32~~31) **Medical Equipment and Supplies**
 - a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
- | ~~33~~32) **Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in General Provisions. If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- | ~~34~~33) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- | ~~35~~34) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- | ~~36~~35) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- | ~~37~~36) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries for to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
- | ~~38~~37) **Personal Care and Convenience**
 - a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

- b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
- c) Home workout or therapy equipment, including treadmills and home gyms,
- d) Pools, whirlpools, spas, or hydrotherapy equipment.
- e) Hypo-allergenic pillows, mattresses, or waterbeds,
- f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

~~39~~38) **Private Duty Nursing** 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 Care Services benefit as specifically stated in the "What's Covered" section.

~~40~~39) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

~~41~~) **Certain Providers** ~~Services you get from a non-covered Provider, as defined in this Booklet. Service you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.~~

Comment [r1]: Moved for alph order

~~42~~) **Residential Treatment Centers** ~~Unless we must cover them by law.~~

~~43~~40) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.

~~44~~41) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

~~45~~42) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.

~~46~~43) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

~~47~~44) **[Religious group opt out to exclude: Sterilization** For sterilization or reversal of sterilization. [This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.]]

~~48~~45) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

~~49~~46) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

~~50~~47) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

~~51~~48) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

[Option — Embedded pediatric and/or adult vision:

~~52~~49) **Vision Services**

a) ~~[Include if only pediatric vision is covered:]~~ Vision services for Members age 19 or older, unless listed as covered in this Booklet.}]

b) ~~[Include if adult vision is covered but limited to exam only option: Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.]~~

e)b) Safety glasses and accompanying frames.

e)c) For two pairs of glasses in lieu of bifocals.

e)d) Plano lenses (lenses that have no refractive power).

~~54e)~~ Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.

~~54f)~~ Vision services not listed as covered in this Booklet.

~~54g)~~ Cosmetic lenses or options.

~~54h)~~ Blended lenses.

~~54i)~~ Oversize lenses.

~~54j)~~ Sunglasses and accompanying frames.

~~54k)~~ For services or supplies combined with any other offer, coupon or in-store advertisement.

~~54l)~~ For Members through age 18, no benefits are available for frames not on the Anthem formulary.

~~54m)~~ _____ Certain frames in which the manufacturer imposes a no discount policy.

~~[When vision services carved out to stand-alone plan:~~

~~53) Vision Services Vision services not described as Covered Services in this Booklet.]~~

~~54)50)~~ **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

[Add if group chooses to cover Bariatric Surgery per mandate option: This Exclusion does not apply to Medically Necessary treatments for morbid obesity if we must cover them by law.]

~~55)51)~~ **[Remove if group chooses to cover Bariatric Surgery per mandate option: Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgeries that reduce stomach size), or gastric banding procedures.]

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **[Optional non-standard: Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless we must cover the Drug you ask for by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your Doctor believes you need to keep using a certain Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover your current Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.]

3. **Compound Drugs** ~~Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.~~

Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.

[Religious group opt out to exclude Contraceptive drugs:]

4. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.]
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "**Prescription Drugs Administered by a Medical Provider**" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Physician believes you require coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the PBM OR FOLLOW THE PROCESS DESCRIBED IN "GRIEVANCE AND EXTERNAL REVIEW PROCEDURES" DESCRIBED LATER IN THIS CERTIFICATE.
9. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
10. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Fluoride Treatments** Topical and oral fluoride treatments. ~~Include only if pediatric dental is embedded.~~ While these services are not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they may be covered under the "Dental Services for Members Through Age 18" benefit. Please see that section for further details.†
13. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
14. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
15. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these may be covered under the "Allergy Services" benefit. Please see that section for details.
16. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
17. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

18. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
21. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
22. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
23. **Sex Change Drugs** Drugs for sex change surgery.
24. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
25. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
26. **Weight Loss Drugs** Any Drug mainly used for weight loss.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one or more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant 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 given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, 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.

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "[Out-of-Area Services](#)" and "[Inter-Plan Programs](#)" later in this section for additional information.

The Maximum Allowed Amount for this Booklet is the maximum amount of reimbursement we will allow for services and supplies:

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding an In-Network Provider or visit [\[www.anthem.com\]](http://www.anthem.com).

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or visit our website at [\[www.anthem.com\]](http://www.anthem.com).

Customer Service is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- *The Out-of-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total out of pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*

- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.
- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of \$1500, or \$450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is \$500, you may receive a bill from the Out-of-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your In-Network Copayment of \$25, your total out of pocket expense would be \$325.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. The form will be sent to you within 15 days. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including

if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem's Service Area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare Providers. Anthem's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside Anthem's Service Area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When covered healthcare services are provided outside of our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card [or go to www.anthem.com] for more information about such arrangements.

Coordination of Benefits When Members Are Insured Under More Than One Plan

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 Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, 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 generally the higher of the Primary and Secondary Plans' allowable amounts. An Out-of-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 [(carve-out) Medicare,] 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 generally 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.

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.

"Recovery" means is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have 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.

Your Member Rights and Responsibilities as an Anthem Blue Cross and Blue Shield Member

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health Plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of Doctors and other health care Providers.
 - Your rights and responsibilities.
 - The rules of your health care Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan.
 - Any care you get.
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (Doctor), also called a PCP, if your health care Plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.

- Follow the care plan that you have agreed on with your Doctors or health care Providers.
- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card

As an Anthem Blue Cross and Blue Shield (Anthem) Member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights" and helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care Providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your Plan and in the way your Plan works.
- Make a complaint or file an appeal about:
 - Your Plan
 - Any care you get
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future, and the right to have your doctor tell you how that may affect your health now and in the future.
- Participate in matters that deal with our policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any Primary Care Physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.

- ~~* To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.~~
 - ~~* Follow the care plan that you have agreed on with your doctors or health care professionals.~~
 - ~~* Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.~~
 - ~~* Follow all Plan rules and policies.~~
 - ~~* Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.~~
 - ~~* Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.~~
- ~~For details about your coverage and benefits, please read the rest of this Booklet.~~

~~**We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.**~~

Grievance and External Review Procedures

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

Definitions

“Appeal” means 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.

“Expedited Review” means 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” means 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 Booklet.

“Grievance” means 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 or Investigational;
- 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 Booklet.

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 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, 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 or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, Georgia 30348-5568]

Our facsimile number is [1-317-287-5968/800-368-3238] if you wish to file your Grievance by fax.

~~For "Dental Benefits for Members Through Age 18" Issues:~~

[Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 551122
Minneapolis, Minnesota
53400-0551/55440-1122]

For "Vision Benefits for Members Through Age 18" ~~For "Vision Benefits for Members Age 19 or Older" Issues:~~

[Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921]

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 **2-five (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 Precertification 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 Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice 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 Precertification 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. An acknowledgment will be sent to you within 3 business days upon our receipt of your Appeal request. 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 Precertification 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. All other Appeals will be resolved by the panel no later than 30 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;
- A Physician with knowledge of your medical condition 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 within three calendar days of our receipt of your Appeal request. 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 utilization review determination; 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 Booklet; 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~~
- ~~4-3. The service is not specifically excluded in this Booklet.~~

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 ~~not~~ received by us ~~after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance~~ within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the 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.]

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group;

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse. ~~as recognized under the laws of the state where the Subscriber lives.~~ For information on spousal eligibility please contact the Group.
- **[Domestic partner coverage:** The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the [same] [or opposite] sex who **[Standard only when affidavit used:** has signed the Domestic Partner Affidavit certifying that he or she] is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

[Standard only when affidavit used: To apply for coverage as Domestic Partners, both the Subscriber and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.]

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstance:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or a mental or physical disability. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

~~Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Plan unless required by the laws of this state.~~

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse; [or Domestic Partner];
- ~~Subscriber and one child;~~
- Subscriber and child(ren);
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during **[Standard: an Open Enrollment period or during]** a Special Enrollment period ~~[Optional: or as a Late Enrollee]~~, as described below.

[Standard / Open Enrollment: Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.]

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan **[Standard: prior to Open Enrollment]** if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium **or contribution to premium** or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- **Lost employer contributions towards the cost of the other coverage;**
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they **may apply for coverage at any time during the year as a Late Enrollee.** ~~[Standard: However, you~~ will not be eligible to enroll until the next Open Enrollment Period.]

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31 day period you should submit an application / change form to the Group, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying Us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<u>For Subscribers:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
<u>For Dependents:</u> A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months

Initial Qualifying Event	Length of Availability of Coverage
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
<u>For Dependent Children:</u>	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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.

Conversion Privilege

The following only applies if you are covered through a Group that is defined as a Small Employer under Indiana law. A Subscriber and any eligible Dependents who have been continuously covered under this Plan, or any group coverage it replaced, for at least ninety (90) days are entitled to an individual conversion plan under the following conditions:

- The Subscriber or Member loses coverage under this Plan as a result of:
 1. termination of employment;
 2. reduction of hours;
 3. marriage dissolution;
 4. or attainment of limiting age.
- The Subscriber or Member is not eligible for federal continuation coverage (COBRA).
- The Subscriber or Member requests an individual conversion plan within thirty (30) days after the loss of Group coverage.

The Subscriber or Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period, Deductibles, or Out of Pocket amounts satisfied under this Plan. The Deductible, Coinsurance and Copayments amounts under the conversion plan may be different than those under this coverage.

Coverage under the conversion plan shall terminate for the following reasons:

- Non-payment of Premiums; or
- Cancellation of the individual conversion plan by the Member or Subscriber.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave. Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

“Military service” means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "What's Not Covered" section.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the Group for any of Anthem Insurance Companies, Inc.'s obligations to the

Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

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.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against [Anthem] based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us with timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

Your In-Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/ Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive gift cards and use them for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives

such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

~~We may offer health or fitness related program options for purchase by your Group. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed and could be discontinued at any time. If your Group has selected one of these options, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors when administered according to state or federal law. However, if it is unreasonably difficult due to a medical condition for you to achieve the standards for a reward under such a program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive gift cards and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)~~

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Athletic Trainer

Please see the "What's Covered" section for details.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount the Provider charges.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in "Benefits After Termination."

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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 "What's Not Covered" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem Insurance Companies, Inc. for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

[Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.]

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does **not** include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

~~The most you pay during a Benefit Period for Covered Services before your Plan begins benefits. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Schedule of Benefits" for details.~~

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Predetermination

Please see the section "Getting Approval for Benefits " for details.

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- ~~2) Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.~~
- 3) Insulin, diabetic supplies, and syringes.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

~~A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Covered Providers are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.~~

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by state regulatory agencies.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Small Employer

Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on at least fifty percent (50%) of the working days of the employer during the preceding calendar year, employed at least two (2) but not more than fifty (50) eligible employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the "What's Covered" section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.