



You've made a good decision in choosing Blue AccessSM

Indiana State Police

For more information, visit our web site at anthem.com

1/1/2013

Table of Contents

1 Health Benefit Booklet

M-1

Administered by Anthem Insurance Companies, Inc.



Administered by Anthem Insurance Companies, Inc.

Your Health Benefit Booklet

Health Benefit Booklet

Blue Access

administered by:

Anthem Insurance Companies, Inc.

120 Monument Circle

Indianapolis, Indiana 46204

Anthem Insurance Companies, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

1 BENEFIT BOOKLET

This Benefit Booklet has been prepared by the Contractor, on behalf of the State, to help explain your health benefits. This document replaces and supersedes any Benefit Booklet or summary that you have received previously.

Please refer to this Benefit Booklet whenever you require health services. It describes how to access medical care and what health services are covered by the Plan.

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

Many words used in the Benefit Booklet have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated.

This Health Benefit Booklet also contains Exclusions, so please be sure to read this Health Benefit Booklet carefully.

This Booklet is not a guarantee of coverage. The benefits information outlined in this booklet is provided for your information only. The booklet itself is not a guarantee of coverage. The actual benefits you may receive are dependent upon your enrollment (i.e., health (including prescription drugs and vision), and/or dental). For additional information on which coverage option you are currently enrolled in, please contact customer service at 1-877-814-9709.

2 FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Contractor's 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 the Contractor's 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.

Contents

1	BENEFIT BOOKLET	M-3
2	FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES	M-3
	Choice of Primary Care Physician	M-3
	Access to Obstetrical and Gynecological (ObGyn) Care	M-3
3	DEFINITIONS	M-7
4	ELIGIBILITY AND ENROLLMENT	M-16
	OVERVIEW OF IMPORTANT INFORMATION	M-16
	Plan descriptions	M-16
	Eligibility	M-17
5	YOUR RIGHTS AND RESPONSIBILITIES AS AN ANTHEM BLUE CROSS BLUE SHIELD ENROLLEE	M-21
6	SCHEDULE OF BENEFITS - BLUE ACCESS	M-23
7	COVERED SERVICES - MEDICAL	M-28
	Preventive Care Services	M-28
	Physician Office Services	M-30
	Inpatient Services	M-30
	Outpatient Services	M-31
	Emergency Care and Urgent Care	M-31
	Ambulance Services	M-33
	Diagnostic Services	M-33
	Surgical Services	M-34
	Elective Second Surgical Opinion Program	M-34
	Therapy Services	M-35
	Home Care Services	M-36
	Human Organ and Tissue Transplant Services	M-36
	Medical Supplies, Durable Medical Equipment, and Appliances	M-36
	Dental Services	M-39
	Dental Care	M-39
	Temporomandibular Joint (TMJ) Syndrome	M-40
	Maternity Services	M-40
	Mental Health/Substance Abuse Services	M-41
	Prescription Drugs	M-42
8	SCHEDULE OF BENEFITS - DENTAL	M-45
9	COVERED SERVICES - DENTAL	M-46
	Covered Dental Services	M-46
10	SCHEDULE OF BENEFITS - VISION	M-48
11	COVERED SERVICES	M-49
	Vision Eye Examination	M-49
	Eyeglass Lenses	M-49
	Frames	M-49
	Elective Contact Lenses	M-50
	Non-Elective Contact Lenses	M-50
	Cosmetic Options	M-50
12	TERMINATION AND CONTINUATION	M-51

Termination M-51

Federal Continuation of Coverage (COBRA) M-51

Cancellation Of The Administrative Service Agreement M-54

Cancellation Of Administrative Service Agreement Enrollment M-54

13 HOW TO OBTAIN COVERED SERVICES M-55

Network Services and Benefits M-55

Non-Network Services M-55

Relationship of Parties (Plan - Network Providers) M-55

Not Liable for Provider Acts or Omissions M-56

Identification Card M-56

14 HEALTH CARE MANAGEMENT M-57

Clinical Coverage Guidelines M-57

Precertification M-58

Precertification Procedures M-59

Case Management (includes Discharge Planning) M-61

15 EXCLUSIONS M-62

16 CLAIMS PAYMENT M-66

How to Obtain Benefits M-66

Maximum Allowed Amount M-66

Services Performed During Same Session M-69

Payment of Benefits M-69

Assignment M-70

Notice of Claim M-70

Claim Forms M-70

Proof of Claim M-70

Time Benefits Payable M-71

Your Choice of Providers M-71

Enrollee's Cooperation M-71

Explanation of Benefits M-71

BlueCard M-71

17 GENERAL PROVISIONS M-73

Entire Administrative Service Agreement M-73

Form or Content of Benefit Booklet M-73

Disagreement With Recommended Treatment M-73

Circumstances Beyond the Control of the Plan M-73

Protected Health Information Under HIPAA M-73

Coordination Of Benefits M-74

Medicare M-78

Physical Examination M-78

Worker's Compensation M-78

Other Government Programs M-79

Subrogation/Reimbursement M-79

Relationship of Parties (State-Enrollee-Plan) M-80

Anthem Insurance Companies, Inc. Note M-80

Notice M-80

Modifications M-81

Conformity with Law	M-81
Clerical Error	M-81
Policies and Procedures	M-81
Waiver	M-81
Plan's Sole Discretion	M-81
Provider Reimbursement	M-81
18 YOUR RIGHT TO APPEAL	M-83
Notice of Adverse Benefit Determination	M-83
Appeals	M-83
How Your Appeal will be Decided	M-84
Notification of the Outcome of the Appeal	M-85
Appeal Denial	M-85
Voluntary Second Level Appeals	M-85
External Review	M-85
Requirement to file an Appeal before filing a lawsuit	M-86
19 Medicare Carve-Out Overview	M-86
20 Medicare Carve-Out Method of Payment Claim Examples	M-88
21 CUSTOMER SERVICE INFORMATION	M-92

3 DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

1. "Ambulatory Surgical Facility" means a facility that is so licensed by the state in which it operates. If that state does not issue such licenses, it means a facility with an organized staff of physicians which:
 - has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
 - provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility;
 - does not provide Inpatient accommodation;
 - is not, other than incidentally, a facility used as an office or clinic for the private practice of a Provider Individual; and
 - has appropriate government planning approval, if required by its state law.
2. "Authorized Service" means a Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance by the Contractor, on behalf of the State, to be paid at the Network level.
3. "Benefit Booklet" means this summary of the terms of your benefits.
4. "Benefit Maximum" means the total dollar amount of benefits for which the Plan is liable as shown in the Schedule of Benefits.
5. "Benefit Period" means the length of time that the Plan will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before this length of time, then the Benefit Period also ends.
6. "Blue Access Plan" means the coverage option which requires Enrollees to use Providers participating in the Contractor's Blue Access Network, or incur out of network penalties as shown in the Schedule of Benefits.
7. "Blue Access Network" means the Blue Access Network established by the Contractor. Blue Access is a Network of health care Providers who have signed an Agreement with the Contractor.
8. "Certified Registered Nurse Anesthetist" means any individual licensed as a Registered Nurse by the state in which he or she practices, holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.
9. "Clinical Laboratory" means a laboratory that performs clinical procedures and is not affiliated or associated with a Hospital, Physician, or other Provider.
10. "COBRA" means Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
11. "Coinsurance" means a specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.
12. "Confinement" means a period beginning on the day an Enrollee enters a Provider Facility as a patient and ending on the day the Enrollee leaves that facility or, if the Enrollee

- was transferred from one Provider Facility to another, the day on which the Enrollee leaves the last facility. In order for a new confinement to begin, a specified number of renewal days must elapse before the Enrollee is readmitted to a Provider Facility.
13. "Contract" means all of the following: 1) this document, all Contract Schedules, Attachments, Addendums and Riders; 2) all applications to establish and change enrollments that have been accepted by the Contractor; 3) all Identification Cards; and 4) Contract for Health Benefit Administrative Services between the State and the Contractor.
 14. "Contract Year" means January 1 through December 31.
 15. "Contractor" means the third party administrator of Hospital, medical, pharmacy, dental and vision benefits provided to the State.
 16. "Copayment" means a specific dollar amount or percentage of Maximum Allowable Amounts for Covered Services indicated in the Schedule of Benefits for which you are responsible. Your flat dollar Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.
 17. "Covered Charges" means charges for covered services to the extent that, in the judgment of the Contractor, as authorized by the State, such charges are not excessive. The Contractor will base its judgment on one or a combination of the following: a) a negotiated rate based on services provided; b) a fixed rate per day; c) the Maximum Allowable Amount for similar Providers who perform like Covered Services.
 18. "Covered Services" means services or supplies specified in this plan for which benefits will be paid when provided by a Provider acting within the scope of his/her/its license. In order to be considered a Covered Service, charges for that service must be incurred while the Enrollee's coverage under this Plan is in force.
 19. "Creditable Service/Creditable Years of Service" for purposes of eligibility for Retirement coverage under this Plan, means years of service with Indiana State Police or years of service in accordance with IC 5-10-8-6.5.
 20. "Custodial Care" means care whose primary purpose is to meet personal rather than medical needs, which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or medical condition, and which can be provided by persons with no special medical skills or training. Such care includes, but is not limited to helping a patient walk, get in or out of bed, and take normally self-administered medicine. The Contractor, on behalf of the State, will determine, based on reasonable medical evidence, whether care is custodial. Such care includes, but is not limited to:
 - assistance with walking, bathing, or dressing;
 - transfer or positioning in bed;
 - normally self-administered medicine;
 - meal preparation;
 - feeding by utensil, tube, or gastrostomy;
 - oral hygiene;
 - ordinary skin and nail care;
 - catheter care;
 - suctioning;
 - using the toilet;
 - enemas; and
 - preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.
 21. "Day Psychiatric Facility" means a facility licensed or certified by the state in which it operates as a Provider of rehabilitation and

therapeutic services for the treatment of mental illness, including Substance Abuse only during the day.

22. "Deductible" - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before benefits are payable under the Plan, for Covered Services each Benefit Period.
23. "Dentist" means a duly licensed dentist or physician who is performing services within the scope of his or her license.
24. "Dependent" – The following persons, provided coverage under the Plan is in effect:
- The Eligible Person's spouse.
 - Any of the following who qualify as the Eligible Person's Dependent(s), until they reach the limiting age:
 - a. Children;
 - b. Stepchildren;
 - c. Adopted children of the Eligible Person or spouse, from the earlier of: (a) the date of placement for the purpose of adoption; (b) the date of entry of a court order granting the adoptive parent custody of the child for adoption; or
 - d. Children for whom the Eligible Person or spouse has legal guardianship when both parents of the child are deceased and one of the parents of the child is a member of the Enrollee's immediate family; the child must reside with the Eligible Person or spouse.
 - e. Those Dependents enrolled through guardianship prior to July 1, 2000 will remain covered Dependents until the earlier of the date:
 - The Dependent reaches the Dependent limiting age; or
 - The Enrollee is no longer the legal guardian of the Dependent; or
 - The Enrollee terminates coverage of the Dependent for
- any reason. A reinstatement of coverage for the Dependent will be subject to the requirements of the insurance plan for the department then in effect.
- In the event a child who is a "Dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the enrollee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the Dependent limiting age is reached, Coverage for the "Dependent" will continue until the Enrollee discontinues his coverage or the disability no longer exists. The Department may require, at reasonable intervals, but no more often than once a year, satisfactory evidence that the disability is continuing.
25. "Dependent Limiting Age" is the date the Dependent reaches age 26.
26. "Diagnostic Services" means the following procedures ordered by a Provider Individual, because of specific symptoms, in order to determine a definite condition or disease:
- radiology, ultrasound, and nuclear medicine;
 - laboratory and pathology;
 - EKG, EEG, and other electronic diagnostic medical procedures;
 - psychological testing; and
 - neuropsychological testing.
27. "Discount" means a pricing that is below retail available to Enrollees for certain services, materials, and/or supplies when utilizing a Network Provider.
28. "Effective Date" means the date coverage for an Eligible Person begins. For an Eligible Person not on a direct bill basis, Coverage

becomes effective on the date they elect the coverage by signing an approved payroll deduction form. Coverage for Dependents takes effect when the employee becomes covered. Newborns are covered from and after the moment of birth for injuries or sickness, congenital deformities, including expenses arising from medical and dental treatment (including orthodontic and oral surgery) for birth defects known as cleft lip and cleft palate, hereditary complications, premature birth and routine nursery care. If these complications occur on a single membership, the baby is covered for thirty-one (31) days from the date of birth. Continued coverage requires election of family coverage by the thirty-first (31st) day from birth.

29. "Eligible Person" means a person who meets the guidelines for eligibility under the Plan.
30. "Elective Contact Lenses" means all contact lenses that are not Non-Elective Contact Lenses.
31. "Emergency (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:
- place an individual's health in serious jeopardy;
 - result in serious impairment to the individual's bodily functions; or
 - result in serious dysfunction of a bodily organ or part of the individual.
32. "Emergency Care (Emergency Services)" means a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.
33. "Enrollee" means anyone provided coverage by the express terms of this Plan, whether enrolled as an Eligible Person or a Dependent.
34. "Excess charges" means eligible Covered Services remaining after benefits for Covered Services have been paid under this Plan's Schedule of Benefits.
35. "Experimental/Investigational" means:
- Any drug, device, diagnostic, product, equipment, procedure, treatment, or supply (service) for which the Contractor, on behalf of the State, determines that one or more of the criteria listed below apply to the service when it is rendered for the evaluation or treatment of a disease, injury, illness or condition. The criteria must apply to the service at the time the Enrollee receives or will receive the service, and must apply to the medical use for which benefits are sought. The service:
 - a. cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
 - b. is the subject of a current drug or device application on file with the FDA;
 - c. is provided as part of a Phase I or Phase II clinical trial, is provided as the experimental or research arm of a Phase III clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service;

- d. is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy among its objectives;
 - e. is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
 - f. is provided pursuant to informed consent documents that describe the service as Experimental/Investigative, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy.
- Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative if the Contractor, on behalf of the State, determines that the service meets any of the four criteria below:
 - a. the scientific evidence does not permit conclusions concerning the effect of the service on health outcomes;
 - b. the service does not improve net health outcome by producing beneficial effects that outweigh any harmful effects;
 - c. the service has not been shown to be as beneficial as any of the established alternative services with evidence demonstrating that the service improves net health outcome as much as, or more than, established alternatives; or
 - d. the service has not been shown to improve net health outcomes under the usual conditions of medical practice outside clinical investigatory settings.
 - Documents relied upon by the Contractor to determine whether services are Experimental/Investigative based on the criteria in the above subsections may, at the Contractor's discretion, on behalf of the State, include one or more items from the following list which is not all inclusive:
 - a. the Enrollee's medical records;
 - b. the written protocol(s) or other document(s) pursuant to which the service has been or will be provided;
 - c. the published, authoritative, peer-review medical or scientific literature regarding the service as it applies to the Enrollee's condition;
 - d. any consent document(s) the Enrollee or Enrollee's representative have executed or will be asked to execute to receive the service;
 - e. the relevant documents of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided;
 - f. any records, regulations, applications or other documents or actions issued by, filed with, or received by the FDA, the Office of Technology Assessment, or other federal or state agencies with similar functions, that the Contractor, on behalf of the State, has in its possession at the time of the review; or
 - g. opinions and evaluations by national medical associations or committees, consensus panels, or other technology evaluation bodies, such as the Blue Cross and Blue Shield Association's Technology Evaluation Center.
 - Services provided solely or primarily to support the administration of an Experimental/Investigative service, or those provided to treat anticipated or unanticipated results of an Experimental/Investigative service, will also be excluded from coverage. Services that are part of the same plan of evaluation or treatment as an

- Experimental/Investigative service, but which, in the opinion of the Contractor, on behalf of the State, would, in the absence of the Experimental/Investigative service be otherwise Medically Necessary, may be considered eligible for coverage, subject to all benefit requirements, limitations and exclusions.
- The Contractor or its designee, on behalf of the State, has the sole authority and discretion to determine all questions pertaining to whether a service is Experimental/Investigative under this Plan.
36. "First Dollar Benefits" means eligible Covered Charges which are not subject to the Plan Deductible.
37. "Freestanding Dialysis Facility" means a facility which is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.
38. "Home Antibiotic IV Therapy" means the administration of antibiotics intravenously, by trained personnel, in the patient's home.
39. "Home Health Care Agency" means an agency meeting Medicare requirements and licensed by the state(s) in which it operates to provide home health care.
40. "Hospital" means a facility which is a short-term, acute care general Hospital and which:
- Is a duly licensed facility;
 - For compensation from its patients, is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of Physicians;
 - Has organized departments of medicine and major surgery; and
 - Provides 24-hour nursing service by or under the supervision of RNs.
41. "Identification Card" means a card issued by the Contractor, on behalf of the State, that bears the Enrollee's name, identifies his or her benefit program by number, and may contain further information about his or her coverage.
42. "Inpatient" means an Enrollee who is treated as a registered bed patient in a Provider facility and for whom a room and board charge is made.
43. "Intermediate Care Facility" means a licensed, residential public or private Substance Abuse rehabilitation facility that is not a Hospital and is operated primarily to provide continuous, structured 24 hour a day or partial, less than 24 hour a day, treatment and care consisting of chemotherapy, counseling, detoxification, and/or ancillary services, identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs.
44. "I.R.B." means Institutional Review Board.
45. "Lenses" means materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.
46. "Licensed Practical Nurse" (LPN) means a person who has graduated from a formal practical nursing education program and is licensed as such by appropriate state authority.
47. "Maximum Allowable Amount" means the maximum amount that the Plan will allow for Covered Services You receive. For more information, see the "Claims Payment" section.
48. "Medically Necessary" or "Medical Necessity" means 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 the Contractor to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Enrollee'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 Enrollee 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 Enrollee'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 Enrollee, the Enrollee's family or the Provider.
 - Not otherwise subject to an exclusion under this Benefit Booklet.
49. "Medicare" means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
50. "Mental Health Treatment Center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a physician. The facility shall be:
- Licensed by the state in which it operates;
 - Funded or eligible for funding under federal or state law; and/or
 - Affiliated with a Hospital under a contractual agreement with an established system for patient referral.
51. "Mental Health Conditions (including Substance Abuse)" means a condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the chapter titled "Mental Disorders".
- Mental Health is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.
 - Substance Abuse is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

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.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

52. "Network Provider" means a Provider who has entered into a contractual agreement or is otherwise engaged by the Contractor, or with another organization which has an agreement with the Contractor, regarding

payment for Covered Services and certain administration functions for the Network associated with the Plan.

53. "Night Psychiatric Facility" means a place where patients with mental illness, including Substance Abuse, who are capable of remaining in the community during the day, can receive treatment at night. A Night Psychiatric Facility may be a ward or wing of a Hospital or psychiatric Hospital or it may be an independent facility that has been licensed or certified by the state in which it operates as a Provider of psychiatric night care and assumes responsibility for coordinating care of all patients.
54. "Non-Elective Contact Lenses" means contact lenses which are provided for reasons that are not cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:
- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses; or
 - High Ametropia-exceeding -12 D or +9 D in spherical equivalent; or
 - Anisometropia-of 3 D or more; or
 - Patients whose vision can be corrected three (3) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.
55. "Non-Network Provider" means a Provider who has not entered into a contractual agreement with the Contractor for the Network associated with the Plan. Providers who have not contracted or affiliated with the Contractor's designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers. Non-Network Providers can balance bill for services over the Maximum Allowable Amount.
56. "Occupational Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.
57. "Out-of Pocket Limit" means the amount of Covered Charges which an Enrollee must pay before his or her benefits under this Plan increase to 100% of Covered Charges.
58. "Out-of-Pocket Limit Exception" Covered Charges for the following do not accrue to the Out-of-Pocket Limit and benefits for them do not increase to 100% of Covered Charges when the Out-of-Pocket Limit is reached:
- Dental
 - Vision
 - Prescription drug Copayments/Coinsurance
59. "Outpatient" means an Enrollee who is a patient, other than a bed patient, at a Provider Facility.
60. "Outpatient Psychiatric Facility" means a facility licensed or certified by the state in which it operates as a Provider of rehabilitation and therapeutic services for the treatment of mental illness, including Substance Abuse, on an Outpatient basis.
61. "Partial Hospitalization" means a psychiatric service offered in a Hospital or in a psychiatric treatment center or in a community mental health center providing medically directed intensive or intermediate short-term psychiatric treatment for a period of less than 24 hours but more than 4 hours a day for any individual patient.
62. "Pharmacy" means any facility so licensed by the state in which it operates.
63. "Physical Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, a person certified as such by an appropriate professional body.

64. "Physician" means a doctor of medicine, a doctor of osteopathy, a psychologist, a chiropractor or any other practitioner of the healing arts who is licensed by the appropriate agency and is practicing within the scope of that license.
65. "Plan" means all of the following:
- This document, all Contract Schedules, Attachments, Addendums and Riders;
 - All applications to establish and change enrollments that have been accepted by the Contractor;
 - All Identification Cards; and
 - Contract for Health Benefit Administrative Services between the Indiana State Police and the Contractor.
66. "Plan Enrollment" means an Eligible Person's or Dependent's right to this Plan's benefits subject to its exclusions, limitations, and conditions.
67. "Plan Year" means the 12 month period beginning each January 1.
68. "Pre-determination" is not a prior authorization for services but is a system that allows you and your Provider to know, in advance, what the estimated benefits payable would be under the Plan for a proposed course of treatment or procedure. The actual benefits you receive under the Plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.
69. "Provider Facility" means Ambulatory Surgical Facility, Hospital, Day/Night Psychiatric Facility, Freestanding Dialysis Facility, Outpatient Psychiatric Facility, Rehabilitation Facility, Residential Short-term Detoxification Facility, and Substance Abuse Facility.
70. "Provider Individual" means Certified Registered Nurse Anesthetist, Licensed Practical Nurse (LPN), Occupational Therapist, Physical Therapist, or Physician.
71. "Psychiatric Hospital" means a facility licensed by the state in which it operates to provide diagnostic and therapeutic services for treatment of mental illness, including Substance Abuse, on an Inpatient basis. If the state does not issue such licenses, it means a facility which is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness and Substance Abuse, if such services are provided by or under the supervision of an organized staff of physicians and if continuous nursing services are provided by RN's.
72. "Psychologist" means a person certified by the Indiana State Board of Examiners in Psychology or, outside the State of Indiana, one who is licensed or certified as such by the state in which he or she practices. Where there is no state licensure or certification, the Psychologist must be certified by an appropriate professional body.
73. "Recovery" means money you receive from another, their insurer or from any "Uninsured Motorist", "Under-insured 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.
74. "Registered Nurse" (RN) means a person who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed as such by appropriate state authority.
75. "Rehabilitation Facility" means a facility licensed by the state in which it operates to provide rehabilitative care on an Inpatient or Outpatient basis. If the state does not issue such licenses, it means a facility which is

primarily engaged in providing medical, social, educational, and vocational services to enable patients, when the services are Medically Necessary, to achieve the highest possible level of functional ability. Services must be provided by or under the supervision of an organized staff of physicians and continuous nursing services must be provided under the supervision of Registered Nurses.

76. "Residential Short Term Detoxification Facility" means a facility licensed or certified by the state in which it operates to provide 24-hour supervision in a structured therapeutic environment for the treatment and resocialization of Substance Abuse patients.
77. "Respiratory Inhalation Therapist" means a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.
78. "Semi-private room" means the charge made by a Hospital for a room containing two beds.
79. "Speech Pathologist" or "Speech Therapist" means a person so licensed by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as a Speech Pathologist or Speech Therapist by an appropriate professional body.
80. "Skilled Care" means: (1) the recognition and utilization of professional methods and procedures in the assessment, observation, or treatment of an illness or injury; and (2) must be performed by or under the supervision of licensed health care personnel.
81. "Spouse" means the person recognized as the Eligible Person's husband or wife under the laws of the State of Indiana.
82. "State" means the legal entity (The Indiana State Police) contracting with the Contractor for the administration of dental, vision, pharmacy, and health care benefits.
83. "Substance Abuse" is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.
84. "Substance Abuse Facility" means a facility licensed or certified by the state in which it operates as a Provider of detoxification and/or rehabilitation treatment for Substance Abuse patients.

4 ELIGIBILITY AND ENROLLMENT

OVERVIEW OF IMPORTANT INFORMATION

Plan descriptions

Active and Retiree Employees

The Blue Access Plan requires the Enrollee to use Providers participating in the Blue Access Network. If services are received from a Non-Network Provider, you will receive a 40% penalty. This penalty does not apply in

emergency situations. By using Blue Access Providers, your Out-of-Pocket expenses are reduced. The Deductible is \$750.00 per Enrollee or \$1,500.00 per family. There are two options available for retirees:

- Basic Plan - This Plan uses the Blue Access Network and is only Medical and Prescription Drug coverage.
- Optional Plan - This Plan uses the Blue Access Network and includes Medical, Prescription Drug, Vision and Dental coverage.

Blue Access Network

As an Enrollee of the Blue Access Plan, to receive full benefits, you are required to receive health care services from a Provider who belongs to the Blue Access Provider Network.

If you receive services from a Non-Network Provider or some out-of-state Providers, you will be required to pay an additional 20% of the Covered Charges, and may be balance billed for charges over the Maximum Allowable amount.

- Is age 60, has completed 15 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 55, age plus years of Creditable Service equals 85 or more, and is immediately eligible for an unreduced pension benefit.

Additional eligibility requirements for retiree coverage:

Employees hired prior to December 31, 2010 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan by no later than January 1, 2011 and maintain continuous coverage from that date to date of separation of employment with the Department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes Creditable Coverage under this provision.

Employees hired after December 31, 2010 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan within the first 30 days of employment and maintain continuous coverage from that date to date of separation of employment with the Department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes Creditable Coverage under this provision.

A retiree must elect coverage on the first day he or she becomes eligible, or within 30 days of the eligibility date. Late entrants (after the 30 day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Premium contributions for retirees covered under the Indiana State Police Pension Fund are paid directly to the Contractor by monthly coupon billing or by deduction from the pension check. All retirees covered by PERF must be coupon billed.

Retirees upgrading from the basic plan to the optional plan must maintain the upgraded coverage for a period of not less than three years before reducing coverage.

Eligibility

Employees

All active full-time Indiana State Police employees regularly scheduled to work not less than 37 $\frac{1}{2}$ hours per week are eligible, as are disabled employees, their spouses and their eligible "Dependents".

An eligible Dependent of an employee becomes eligible for coverage on the effective date of the employee's coverage.

If a Dependent, other than a newborn infant of an Enrollee, is confined in a hospital on the date his or her coverage would otherwise begin, his or her coverage will become effective upon final medical release from such confinement.

Retirees

A retiree becomes eligible for coverage either: 1) the month he or she retires (if the retirement becomes effective on the first day of that month); or 2) the first day of the month following the date retirement becomes effective, if he or she:

- Has completed 25 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 65, has completed 10 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or

Retiree Dependents

An eligible Dependent of a retiree becomes eligible for coverage on the effective date of the retiree's coverage.

"Dependent" – The following persons, provided coverage under the plan is in effect:

- The Eligible Person's spouse.
- Any of the following who qualify as the Eligible Person's Dependent(s), until they reach the limiting age:
 1. Children;
 2. Stepchildren;
 3. Adopted children of the Eligible Person or spouse, from the earlier of: (a) the date of placement for the purpose of adoption; (b) the date of entry of a court order granting the adoptive parent custody of the child for adoption; or
 4. Children for whom the Eligible Person or spouse has legal guardianship when both parents of the child are deceased and one of the parents of the child is a Enrollee of the Enrollee's immediate family provided the child resides with the Eligible Person or spouse except in those cases when the child is no longer a same household resident while a full time student at an accredited educational institution.
 5. Those Dependents enrolled through guardianship prior to July 1, 2000 will remain covered Dependents until the earlier of:
 - a. The Dependent reaches the Dependent limiting age: or
 - b. The Enrollee is no longer the legal guardian of the Dependent: or
 - c. The Enrollee terminates coverage of the Dependent for any reason. In this occurrence, any reinstatement of coverage for the Dependent will be subject to the requirements of the insurance plan for the department then in effect.

- In the event a child who is a "Dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the Enrollee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the Dependent Limiting Age is reached. Coverage for the "Dependent" will continue until the Enrollee discontinues his coverage or the disability no longer exists. The department may require, at reasonable intervals, but no more often than once a year, satisfactory evidence of the disability is continuing.

"Dependent Limiting Age" is the date the Dependent reaches age 26.

Family Security

If an employee or retiree is covered under this program at the time of his or her death, his or her Dependents, including spouse, who are also covered will be eligible to remain covered under this Plan under the Family Security Program. Until the occurrence of one of the following events, whichever is earliest:

- The date of remarriage of the surviving spouse, if any; or
- The date a Dependent ceases to meet this Plan's definition of a Dependent.

Remaining covered Dependents may continue their coverage at the appropriate Dependent premium rate based on the retiree rate structure. Election to continue coverage must be made within 30 days of the death of the employee/retiree. Coverage elected will become effective on the first day of the month following the Enrollee's death. Late entrants (after the 30-day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Coverage for a surviving spouse will cease on the earlier of:

- The date or remarriage of the surviving spouse; or
- The date the surviving spouse dies.

Any coverage which is continued for dependent children because of the death of a covered employee or retiree will not cease because of the death of the surviving spouse within the six (6) month period following the date of the employee's or retiree's death.

The dependent benefits payable after the death of the employee or retiree will be those in effect for the dependents on the day prior to the death of the employee or retiree.

Line of Duty

Dependents, including spouses, of employees killed in the Line of Duty shall be offered health insurance coverage in accordance with IC 5-10-14. This coverage will be paid for by the Department. Dependents' coverage is subject to the Eligibility requirements of the Plan.

A surviving spouse may add additional dependents to the Plan that are acquired after the line of duty death. These Dependents are subject to the eligibility requirements of the Plan, and the premium will be based on the retiree rate structure, as follows:

One Dependent – Dependent Only rate.

Two Dependents – Retiree plus One Dependent rate.

Three or more Dependents – Retiree plus Multiple Dependents rate.

Enrollment

Participation in the plan(s) is voluntary, and employees may enroll as follows:

- New employees are given thirty-one (31) days from their date of hire to enroll in any of the programs offered by the Indiana State Police. Coverage becomes effective on the date they elect coverage by signing an approved payroll deduction form. Coverage

for Dependents takes effect when the employee becomes covered.

- Dependents born or acquired after the date of enrollment must be added by completion of the appropriate forms within thirty-one (31) days of the marriage, birth, etc.
- Enrollment or changes not in accordance with above paragraphs may be made as follows:
 1. During designated open enrollment periods;
 2. Based upon the evidence of insurability policy under the TPA;
 3. Based on the qualifying events interim in the IRS Code Section 125.

Newborn Infant Coverage

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

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:
 - a. The date of placement for the purpose of adoption; or
 - b. The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;

2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
3. Continues unless required action as described below is taken.

Single Policy

To be covered beyond the first 31 days on a single policy, the newborn must be added to the Enrollee's plan membership. **The Enrollee will need to contact the Human Resources Division to obtain the appropriate enrollment forms.** The Enrollee will be liable for the higher premium for the entire pay period in which the child was added.

Family Policy

The Contractor will automatically add a newborn child to an existing family membership. The Contractor will send a notice to the Enrollee that an enrollment form must be completed with the child's name. **The Enrollee will need to contact the Human Resources Division to obtain the enrollment form.**

Note: This procedure does not apply in cases of:

- Adoption
- Marriage
- Divorce
- Guardianship
- Change in Dependent status.

In these cases, you must contact the Human Resources Division to obtain the appropriate enrollment forms.

Qualified Medical Child Support Order/Court Ordered Health Coverage

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll

your child under this Plan, the State will permit your child to enroll at any time without regard to any open enrollment limits and shall provide the benefits of this Plan in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Plan will be paid, at the Contractor's discretion, on behalf of the State, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Plan will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Contractor directly.

Contributions

Persons who have elected coverage under the medical, vision and dental plans must authorize payroll deductions to pay their portion of the cost.

Applications

To obtain coverage with the Indiana State Police Health Care Benefit Plan, an Eligible Person must complete and submit an application to the Indiana State Police Human Resources Division. Acceptance of the application is shown by delivery of an identification card showing the Eligible Person's name and identification number.

5 YOUR RIGHTS AND RESPONSIBILITIES AS AN ANTHEM BLUE CROSS BLUE SHIELD ENROLLEE

As an Anthem Blue Cross Blue Shield (Anthem) Enrollee 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 privacy rules.
- Get information about Anthem's company and services, and Anthem's network of doctors and other health care Providers.
- Get more information about your rights and responsibilities and give Anthem your thoughts and ideas about them.
- Give Anthem your thoughts and ideas about any of the rules of your health care plan and in the way your Plan works.
- Make a complaint or file an appeal about:
 - Your health care Plan
 - Any care you get
 - Any Covered Service or benefit ruling that your health care Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the Anthem's 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.

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 to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.

- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care Plan rules and policies.
- Let Anthem's Customer Service department know if you have any changes to your name, address or family members covered under your Plan.
- Give Anthem, the Employer, 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 the Employer.

For details about your coverage and benefits, please read your Benefit Booklet.

The Contractor and Plan are committed to providing quality benefits and customer service to Enrollees. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Enrollee Rights and Responsibilities statement.

6 SCHEDULE OF BENEFITS - BLUE ACCESS

The Schedule of Benefits is a summary of the Copayments, Coinsurance and other limits when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Benefit Booklet including any attachments or riders. **This Schedule of Benefits lists the Enrollee’s responsibility for Covered Services.**

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

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

1. **Ambulatory patient services,**
2. **Emergency services,**
3. **Hospitalization,**
4. **Maternity and newborn care,**
5. **Mental health and substance use disorder services, including behavioral health treatment,**
6. **Prescription drugs,**
7. **Rehabilitative and habilitative services and devices,**
8. **Laboratory services,**
9. **Preventive and wellness services, and**
10. **Chronic disease management and pediatric services, including oral and vision care.**

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

Benefit Period	Calendar Year	
Dependent Age Limit	To the date the Dependent reaches age 26.	
Deductible	Network	Non-Network
Per Enrollee	\$750	\$1,500
Per Family	\$1,500	\$3,000

Note: Network and Non-Network Deductibles are separate and do not accumulate toward each other.

Out-of-Pocket Limit	Network	Non-Network
Per Enrollee	\$1,500	\$3,000
Per Family	\$3,000	\$6,000

Note: Charges for Dental, Vision, and Prescription Drug Copayments/Coinsurance do not apply to the Out-of-Pocket expense limit and benefits for them do not increase to 100% when the Out-of-Pocket expense limit is reached. The Deductible is **not** included in the Out-of-Pocket limit.

Note: Network and Non-Network Out-of-Pocket Limits are separate and do not accumulate toward each other.

Covered Services	Coinsurance/Copayments/Maximums	
	Network	Non-Network *
Preventive Care	No Coinsurance up to the Maximum Allowable Amount	Coinsurance based on setting where Covered Services are received, not subject to the Deductible.
Diabetes Self Management	20% Coinsurance	40% Coinsurance
Physician Office Services	20% Coinsurance	40% Coinsurance
Allergy testing and injections	20% Coinsurance	40% Coinsurance
Inpatient Services	20% Coinsurance Unlimited (Combined Network and Non-Network)	40% Coinsurance
Outpatient Services	20% Coinsurance	40% Coinsurance
Diagnostic Services	20% Coinsurance	40% Coinsurance
Preadmission Testing	20% Coinsurance	40% Coinsurance

Emergency Room	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
-----------------------	-----------------	---

Urgent Care	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
--------------------	-----------------	---

Note: Treatment must be received within 72 hours of the onset of the illness or accident, in order for charges to be covered under this benefit.

Ambulance Services	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
---------------------------	-----------------	---

Outpatient Therapy Services	20% Coinsurance	40% Coinsurance
Maximum Visits per Benefit Period for:		
Physical & Occupational Therapy	Unlimited	
Speech Therapy	Unlimited	
Spinal Manipulations	Unlimited	

Radiation and Chemotherapy	20% Coinsurance	40% Coinsurance
-----------------------------------	-----------------	-----------------

Accidental Dental Services	20% Coinsurance	40% Coinsurance
-----------------------------------	-----------------	-----------------

Note: Benefits paid for treatment of dental conditions caused by an accidental injury as long as treatment is received within six (6) months after the accident.

Dental Care

Facility - when necessitated by a concurrent medical condition, mentally or physically impaired Enrollee. 20% Coinsurance 40% Coinsurance

Home Care Services (Unlimited) 20% Coinsurance 40% Coinsurance

Injectable Drugs and Home Infusion (IV) Therapy 20% Coinsurance 40% Coinsurance

Medical Supplies, Equipment and Appliances 20% Coinsurance 40% Coinsurance

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

Maternity Services 20% Coinsurance 40% Coinsurance

Behavioral Health and Substance Abuse Services

Inpatient Facility Services 20% Coinsurance 40% Coinsurance

Inpatient Professional Services 20% Coinsurance 40% Coinsurance

Outpatient Facility Services (Includes Outpatient Hospital/Alternative Care Facility) 20% Coinsurance 40% Coinsurance

Outpatient Professional Services 20% Coinsurance 40% Coinsurance

Office Visits 20% Coinsurance 40% Coinsurance

Other Outpatient Services 20% Coinsurance 40% Coinsurance

Human Organ and Tissue Transplant Services No Coinsurance up to the Maximum Allowable Amount 40% Coinsurance

Covered human organ transplant procedures are: Bone Marrow, Heart, Heart/Lung, Lung, Liver, Pancreas, Kidney/Pancreas, Kidney, and Cornea transplants.

Benefit Period Total of 365 continuous days beginning 1 day immediately prior to a Covered Transplant Procedure or first myeloblation therapy (high dose chemotherapy and/or irradiation)

***You may be balance billed for amounts over the Maximum Allowed Amount.**

Prescription Drugs

Days Supply
 (Days Supply may be less than the amount shown, due to Prior Authorization, Quantity Limits and Utilization Guidelines):

Network Pharmacy	30 day supply
Mail Service	90 day supply
Prescription Drug Deductible Per Enrollee	\$300 - Applies to Retail and Mail Service Program, Network and Non-Network

Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Certificate.

Network Pharmacy:

Generic Formulary Drugs	\$25 per Prescription Order
Brand name Formulary Drugs	\$40 per Prescription Order
Non-Formulary Drugs	50% Coinsurance

Mail Service Program:

Generic Formulary Drugs	\$30 per Prescription Order
Brand name Formulary Drugs	\$80 per Prescription Order
Non-Formulary Drugs	50% Copayment

Non-Network Pharmacy

Generic Formulary Drugs	\$25 per Prescription Order plus 20% of remaining costs.
Brand name Formulary Drugs	\$40 per Prescription Order plus 20% of remaining costs.
Non-Formulary Drugs	70% Coinsurance

Mandatory Maintenance for Mail Service – If you are taking a maintenance medication you are limited to three (3) 30-day fill(s) of the medication at retail. You must then begin using Mail Service to purchase your medication. If you are not sure if your medication is considered a maintenance medication, please make sure you call the PBM’s Mail Service Pharmacy for more information.

Note: Certain Diabetic and Asthmatic supplies are covered in full.

7 COVERED SERVICES - MEDICAL

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. For the Blue Access Plan, care must be received from a Network Provider to be covered at the Network level, except for Emergency Care and Urgent Care. Services which are not received from a Network Provider will be considered a Non-Network Service, unless otherwise specified in this Benefit Booklet. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider.

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

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. **The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment.** To receive maximum benefits for Covered Services, you must follow the terms of the Benefit Booklet, including use of Network Providers, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization/Precertification has been obtained. The Contractor, on behalf of the State, bases its decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Contractor's Medical Policy. The Contractor, on behalf of the State, may also

consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

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

Preventive Care Services

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

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

Preventive Care Services in this section shall meet requirements as determined by federal law. Many preventive care services are covered by this Benefit Booklet with no Deductible, Copayments or Coinsurance from the Enrollee when provided by a Network Provider. That means the Contractor, on behalf of the State, pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.
Examples of these services are screenings for:
 - a. Breast cancer;
 - b. Cervical cancer;
 - c. Colorectal cancer;

- d. High Blood Pressure;
 - e. Type 2 Diabetes Mellitus;
 - f. Cholesterol;
 - g. Child and Adult Obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. Women's contraceptives, sterilization procedures, and counseling. This includes Generic 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.
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
 - c. Gestational diabetes screening.

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

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

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

Diabetes Self Management Training

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

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

Coverage for diabetes self-management training is limited to:

- One (1) visit(s) after receiving an initial diagnosis of diabetes;
- One (1) visit(s) after receiving a diagnosis by a Physician or a podiatrist that represents a significant change in your symptoms or condition and makes changes in your self-management Medically Necessary; and

- One (1) visit(s) for reeducation or refresher training per Benefit Period.

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.

A “visit” means a 2 to 3 hour maximum diabetes education session provided by a Health Care Professional in an Outpatient facility or in a Physician’s or podiatrist’s office.

Physician Office Services

Office services include care in a Physician’s office that is not related to Maternity and Mental Health Conditions, except as specified. Refer to the sections entitled Maternity Services and Mental Health Conditions for services covered by the Plan. For emergency accident or Emergency Medical Care refer to the Emergency Care and Urgent Care section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include injections, serum and allergy testing. When allergy injection, testing or serum is the only charge from a Physician’s office a specific Coinsurance may apply as stated in the Schedule of Benefits under Physician Office Services.

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

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

Therapy Services for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

Inpatient Services

Inpatient Services do not include care related to Maternity, except as specified. Refer to the sections entitled Maternity Services for services covered by the Plan. Inpatient Services include:

- charges from a Hospital or other Provider for room, board and general nursing services;
- ancillary services; and
- professional services from a Physician while an Inpatient.

Room/Board and General Nursing Services

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

Ancillary Services

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

Professional Services

- **Medical care visits** limited to one visit per physician, each day, for separate diagnosis. Covered services do not include inpatient medical visits during surgery admissions, unless the visit is for a diagnosis that is different from the surgery diagnosis.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Inpatient consultations are covered in full. Staff consultations required by Hospital rules are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Outpatient Services

Outpatient Services include both facility and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. Outpatient Services do not include care that is related to Maternity, except as otherwise specified. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, any Coinsurance will still apply to these services.

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

Emergency Care and Urgent Care

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Medically Necessary services which the Contractor, on behalf of the State, determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider.

Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Enrollee **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance or Deductible.

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

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

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week.

Follow-up care is not considered Emergency Care.

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

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Coinsurance for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Contractor or verify that your Physician has notified the Contractor of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Contractor is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Contractor, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. **If your Provider does not have a participation agreement with the Contractor or is a BlueCard Provider, you will be financially responsible for any care the Contractor, on behalf of the State, determines is not Medically Necessary.**

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

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Covered Services rendered by a

Non-Network Urgent Care Center will be covered as a Network service, however the Enrollee **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

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

See your Schedule of Benefits for benefit limitations.

Obtaining Emergency or Urgent Care

If you need Emergency Care or Urgent Care even while you are traveling outside of the Service Area, these are the step-by-step instructions you need to follow to help ensure you receive coverage. Treatment must be received within 72 hours of the accident to be covered under this benefit.

- Know the difference between an Emergency and an Urgent Care situation.
- If you are experiencing an Emergency situation, call 9-1-1 or go to the nearest Hospital. If you are experiencing an Urgent Care medical problem, go to an Urgent Care center. If there is not one nearby, then go to the Hospital.
- Call your Physician or the Contractor within 48 hours.

- Ask if the Hospital or Urgent Care center contracts with the local Blue Cross and Blue Shield Plan.
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, show your Identification Card to the Hospital or Physician. If it does not contract with the local Blue Cross and Blue Shield Plan, you will need to pay the bill and file a claim form.
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, the Hospital or Urgent Care Center will verify your membership and get your benefit information from a nationwide electronic data system.
- After you are treated, your claim is sent to the Contractor. You only have to pay the Hospital or Urgent Care Center any Coinsurance or Deductibles as stated in your Plan.
- You may receive an Explanation of Benefits form depending on what services you received.

Travel outside the country:

- Go to the nearest health care facility.
- Once your care is completed, you will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for you.) **Keep all your receipts!**
- When you return home, call the Contractor at the number on the back of your ID card or stop by your Indiana State Police Human Resources Division and ask for a claim form.
- Fill out the claim form and submit it with your receipts to the address on the form. (The amount submitted must be in American dollars.)
- You will be reimbursed based on the benefits of your Plan.

Ambulance Services

Local transportation by a vehicle designed, equipped and used only to transport the sick and injured:

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

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

When ordered by an employer, school, fire, or public safety official and the Enrollee is not in a position to refuse.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

Diagnostic Services

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

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Magnetic Resonance Imaging (MRI);
- CAT scans;
- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope tests;

- Ultrasound services;
- Allergy tests;
- Electrocardiograms (EKG);
- Electromyograms (EMG) except that surface EMG's are not Covered Services;
- Echocardiograms;
- Pre-admission testing. Covered Services are necessary tests and studies performed in an Outpatient setting before an Inpatient Hospital admission. Services are not covered if:
 1. performed to establish a diagnosis;
 2. repeated after you are admitted;
 3. performed more than 72 hours before you are admitted; or
 4. you cancel or postpone the admission.
- Positron emission tomography (PET scanning).

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

When Diagnostic radiology is performed in a Physician's Office, any Coinsurance will still apply.

Surgical Services

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by the Plan.

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

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Elective Second Surgical Opinion Program

When a Physician recommends surgery, a second surgical opinion by another Physician is covered. If the second Physician does not recommend surgery, a third opinion will be covered. Any related diagnostic tests billed by the Physician are included in this benefit, not subject to any Outpatient diagnostic maximums of your Plan.

The consulting Physician(s) cannot be in practice with the Physician who recommended surgery. Your responsibility is a 40% Coinsurance of the Maximum Allowable Amount for elective second surgical opinions.

Mastectomy Notice

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

- reconstruction of the breast on which the mastectomy has been performed;

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

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

Sterilization

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

Therapy Services

Coverage for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Services, or Home Care Services is limited to the following:

Physical Medicine Therapy Services

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

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.
- **Speech therapy** is a covered item only when received as a result of a congenital anomaly or following an accident, stroke, surgery or disease.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, and vocational therapies (e.g. hobbies, arts and crafts).
- **Spinal manipulation services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Spinal Manipulations as specified in the Schedule of Benefits.

Other Therapy Services

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

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Physical Medicine and Rehabilitation Services

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

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

Certain Therapy Services rendered on an Inpatient or Outpatient basis are limited. See the Schedule of Benefits.

Home Care Services

Services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services

- Therapy Services (Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.)
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing
- Custodial Care is a Non-Covered service.

Home infusion therapy will be paid only if you obtain prior approval from the Home Infusion Therapy Subcontractor (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes services and supplies for Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, IV pain management and IV home chemotherapy.

Human Organ and Tissue Transplant Services

Covered human organ transplant procedures are: Bone Marrow, Heart, Heart/Lung, Lung, Liver, Pancreas, Kidney/Pancreas, Kidney, and Cornea transplants. Benefits paid for transplant services are the same as any other condition.

NOTE: No additional transplant procedures are Covered Services under this Plan.

Medical Supplies, Durable Medical Equipment, and Appliances

Medical and Surgical Supplies

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features

which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Covered Services include, but are not limited to:

- **Medical and surgical supplies** - Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly. Prescription drugs and biologicals that cannot be self administered and are provided in a Physician's office.
- **Durable medical equipment** - The rental (or, at the Contractor's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. Non-covered items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports, and corsets or other articles of clothing.
- **Prosthetic appliances** - Artificial substitutes for body parts and tissues and

materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

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

Covered Services for prosthetic appliances include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant)
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act;
4. Minor devices for repair such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract

extraction is performed, intraocular lenses are usually inserted during the same operative session);

7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered)
8. Cochlear implant;
9. Electronic speech aids in post-laryngectomy or permanently inoperative situations;
10. "Space Shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent;
11. Hairpiece or wigs, required as a direct result of hair loss due to chemotherapy or radiation.

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

1. Dentures, replacing teeth or structures directly supporting teeth;
2. Dental appliances;
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4. Artificial heart implants;
5. Hairpieces for male pattern alopecia (baldness);
6. Wigs (except as described above);

- Orthotic devices - Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part . The cost of casting, molding, fittings, and adjustments are included.

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

1. Cervical collars;

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

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

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

Non-Covered Services include but are not limited to:

1. Orthopedic shoes;
2. Foot support devices, such as arch supports and corrections to footwear, are covered only when prescribed by a physician.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);

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

1. determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and

2. not solely for comfort or convenience.

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

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

Dental Services

Related to Accidental Injury

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

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

- oral examinations;

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

Non-covered services for accidental dental include, but are not limited to:

- charges for any Investigational/Experimental treatment, procedure, facility, equipment, drug, device, or supply;
- surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin), except for reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process.

Other Dental Services

The only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Dental Care

Anesthesia and Hospital charges for dental care, for a Enrollee less than 19 years of age or a Enrollee who is physically or mentally disabled, are covered if the Enrollee requires dental treatment to be rendered 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, are the utilization standards for determining whether performing dental

procedures necessary to treat the Enrollee's condition under general anesthesia constitutes appropriate treatment. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Temporomandibular Joint (TMJ) Syndrome

Covered services for TMJ Syndrome are Inpatient Hospital charges, office visits, Diagnostic Services, Orthotic appliances, equilibrations, crowns, orthodontia, and Surgery.

Your Plan pays 80% of the Maximum Allowable Amount for services related to TMJ Syndrome, subject to Plan Deductible.

Maternity Services

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

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

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

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

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines

further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. The antepartum, intrapartum, and postpartum course of the mother and infant;
 2. The gestational stage, birth weight, and clinical condition of the infant;
 3. The demonstrated ability of the mother to care for the infant after discharge; and
 4. The availability of postdischarge follow-up to verify the condition of the infant after discharge.
- Covered Services include at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage includes, but is not limited to:
 1. Parent education;
 2. Physical assessments;
 3. Assessment of the home support system;
 4. Assistance and training in breast or bottle feeding;
 5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

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

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

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

Multiple Births

Not more than one deductible will be deducted from the total covered expenses incurred in a calendar year for two or more Dependents born in a multiple birth if those covered expenses are incurred in the same calendar year in which they are born and are due to:

- premature birth;
- abnormal congenital condition; or
- injury which is received or sickness which starts not more than 30 days after their birth.

Mental Health/Substance Abuse Services

Covered Services include but are not limited to:

- **Inpatient services** - individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. For Mental Health, day limits per Enrollee are 365 per confinement with 90 days per renewal. For Substance Abuse, day limits per Enrollee are 60 days per admission.
- **Partial hospitalization** - a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least 4 to 6 hours of treatment per day. Patients are expected to participate up to 5 days per week.
- **Intensive Outpatient treatment or day treatment** - a structured program, offered at least 3 times per week for at least 3 hours per day. The program may be managed by a licensed mental health professional with a psychiatrist on staff. Therapy is provided by a licensed mental health professional.
- **Outpatient treatment, or individual or group treatment** - office-based services, for example: diagnostic evaluation, counseling, psychotherapy, family and marital therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist. Covered services also include electroshock therapy when administered by a physician, anesthesia for electroshock therapy; psychological testing when administered by an employee of a covered psychiatric facility; counseling for others in the eligible person's family, to allow 20 visits per occurrence with

a limit of two occurrences per lifetime for outpatient Substance Abuse. Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

Non-Covered Mental Health/Substance Abuse Services:

- Residential Treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
 - Custodial or Domiciliary care.
 - Supervised living or halfway houses.
- Copayments, Coinsurance and limits are specified in the Schedule of Benefits.

Prescription Drugs

Pharmacy Benefits Manager

The pharmacy benefits available to you under this Plan are managed by the Contractor's affiliate, Pharmacy Benefits Manager (PBM). PBM is a pharmacy benefits management company with which the Contractor contract to manage your pharmacy benefits. PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, and provides clinical services that include Formulary management.

The management and other services PBM provides include, among others, making recommendations to, and updating, the Formulary and managing a network of retail pharmacies and operating a Mail Service pharmacy. PBM, in consultation with the Contractor, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns.

You may request a copy of the Formulary by calling the Contractor at the number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary is not a guarantee of coverage. Refer to the Prescription Drug benefit sections in this Plan for information on coverage, limitations and exclusions.

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

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

For a list of the current drugs requiring Prior Authorization, please contact the Contractor at the number on the back of your ID card. The Formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary is not a guarantee of coverage. Refer to the Prescription Drug benefit sections in

this Plan for information on coverage, limitations and exclusions.

Please ask your Provider or Network pharmacist to check with the Contractor or with PBM to verify Formulary Drugs, any quantity limits, or appropriate brand or Generic Drugs recognized under the Plan.

Therapeutic Substitution of Drugs is a program approved by the Contractor and managed by PBM. This is a voluntary program designed to inform Enrollees and Physicians about Formulary or generic alternatives to non-Formulary and Formulary Brand drugs. The Contractor, or PBM, may contact you and your prescribing Physician to make you aware of Formulary or Generic Drug substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For a list of therapeutic drug substitutes that have been identified, contact the Contractor by calling the telephone number on the back of your ID card. The therapeutic drug substitutes list is subject to periodic review and amendment.

Covered Prescription Drug Benefits

Covered Services include only:

- Prescription Legend Drugs;
- Injectable insulin and syringes used for administration of insulin;
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical foods 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 intravenously under the direction of a Physician.

Not Covered under Prescription Drug Benefits

- Over the counter drugs, or Prescription Legend Drugs with over the counter equivalents;
- Off label use, except as otherwise prohibited by law, or as approved by the Contractor or PBM;
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order;
- Charges for the administration of any drug;
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician;
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin;
- Drugs in quantities which exceed the limits established by the Plan;

Copayment/Coinsurance – Each Prescription Order may be subject to a Copayment/Coinsurance. If the Prescription Order includes more than one covered drug, a separate Copayment/Coinsurance will apply to each covered drug. Your Prescription Drug Copayment/Coinsurance will be the lesser of your scheduled Copayment/Coinsurance amount or the retail price charged for your prescription by PBM or the pharmacy that fills your prescription. Please see the Schedule of Benefits for the applicable Copayment/Coinsurance. If you receive Covered Services from a Non-Network Pharmacy, a Copayment/Coinsurance amount will also apply.

Days Supply – The number of days supply of a drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits.

Formulary – The Plan follows a drug Formulary in determining payment and Covered

Services. You will be responsible for an additional Copayment/Coinsurance amount depending on whether a Formulary or non-Formulary drug is obtained. Please see the Schedule of Benefits.

Payment of Benefits

The amount of benefits paid is based upon whether you receive Covered Services from a Network Pharmacy, a Non-Network Pharmacy, or a Mail Service Program. It is also based upon whether you obtain a Generic or Brand Name Prescription Legend Drug and whether Formulary Prescription Legend Drugs were dispensed. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

Note: If you obtain a Brand Name Drug, the Brand Name Drug Copayment/Coinsurance will always apply, even in the following situations:

- no Generic Drug equivalent is available;
- the Prescription Order specifies "Dispense as Written;" or
- you chose the Brand Name Drug instead of the Generic Equivalent.

If you choose a Brand Name Drug, or your Provider prescribes a Brand Name Drug and a Generic Formulary Drug is available, you pay the Brand Formulary Drug Copayment/Coinsurance. If you choose a Non-Formulary Drug, or your Provider prescribes a Non-Formulary Drug and a Generic Formulary Drug or Brand Formulary Drug is available, you pay the Non-Formulary Drug Copayment/Coinsurance. Where no Generic Drug is available, you are only responsible for the applicable Formulary or Non-Formulary Drug Copayment/Coinsurance.

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

Your Copayment(s)/Coinsurance and/or Deductible amounts will not be reduced by any

discounts, rebates or other funds received by the Subcontractor and/or the Plan from drug manufacturers or similar vendors.

For Covered Services provided by a Network Pharmacy or through Mail Service, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts.

For Covered Services provided by a Non-Network Pharmacy, after you have paid all applicable Deductibles and/or Copayments/Coinsurance, the Plan will pay the amount shown in the Schedule of Benefits of the amount of the Prescription Charge. You are responsible for the remaining portion of the Prescription Charge.

How to Obtain Prescription Drug Benefits

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

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

8 SCHEDULE OF BENEFITS - DENTAL

The Schedule of Benefits is a summary of the amount of benefits the Contractor will pay when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific dental services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Benefit Booklet including any attachments or riders. Benefits for Covered Services are based on the Maximum Allowable Amount. You may be responsible for any balance due between the Provider’s charge and the Maximum Allowable Amount in addition to any Coinsurance, Deductibles, and non-Covered Charges.

Benefit Period Calendar Year

Dental Deductible

Per Person \$50
 Per Family \$150

Maximum Per Benefit Period

For all Dental Services except extraction of impacted or partially impacted teeth and Orthodontia. \$1,500
 For extraction of impacted or partially impacted teeth including anesthesia. \$2,000

Orthodontic Lifetime Maximum \$2,500

Covered Services **Coinsurance/Maximums**

Class I - Preventive and Diagnostic Covered Services (Not subject to the Deductible) 100% of billed charges

The following services are subject to the Deductible:

Class II - Restorative Covered Services 90% of billed charges
 Class III - Prosthodontics Covered Services 70% of billed charges
 Class IV - Orthodontic Covered Services 70% of billed charges

9 COVERED SERVICES - DENTAL

This section describes the Covered Services available under your dental care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the Exclusions section.

Benefits are limited to Covered Services stated in this Benefit Booklet for dental disease, prevention, diagnosis and treatment. Coverage is subject to all the terms and limitations stated in this Benefit Booklet, including special treatment schedules and benefit maximums.

Covered Dental Services

Class I - Preventive and Diagnostic Covered Services

1. Oral examinations, not more than twice a calendar year.
2. Bitewing x-rays, X-rays.
3. Full mouth x-rays, once in a 36 consecutive month period.
4. Oral prophylaxis (cleaning and scaling of teeth), not more than twice in a calendar year.
5. Topical fluoride application, not more than one treatment in a calendar year.
6. Space maintainers.
7. Extractions (except extractions for orthodontics or impacted or partially impacted teeth).
4. Endodontic treatment (pulp infection and root canal therapy).
5. Injections of antibiotic drugs.
6. Sealants for dependent children under 19 years of age on posterior teeth.
7. Apicoectomy (considered a separate service if performed with root canal therapy)
8. Gingivectomy or gingivoplasty, per quadrant.
9. Osseous surgery, per quadrant. If more than one surgical service is performed per quadrant, only the most inclusive surgical service performed will be a Covered Service under this benefit. Flap entry and closure is considered part of the dental service of osseous surgery and osseous graft.

Class II - Restorative Covered Services

1. Fillings, including silver amalgam, silicate and acrylic restorations.
2. Administration of general anesthetics when medically necessary and administered in connection with oral surgery.
3. Periodontal treatment (diseases of gums).

Class III - Prosthodontics Covered Services

1. Crowns (porcelain and/or gold).
2. Complete dentures.
3. Partial dentures.
4. Bridge pontics (gold, porcelain, or plastic).
5. Abutment crowns (gold, porcelain, or plastic).
6. Implants.

Class IV - Orthodontic Covered Services

1. Orthodontic diagnostic procedures (including cephalometric X-rays).
2. Surgical therapy (surgical repositioning of the jaw, facial bones, and/or teeth to correct malocclusion).
3. Appliance therapy (braces) including related oral exams, surgery and extractions.

Implants

Benefits for implants include:

- Surgical placement of implants
- Implant supported Prosthetics
- Implant maintenance
- Repair of an implant
- Removal of an implant

Limitations

Covered services for surgery involving the teeth or peridontium are limited to the following:

- Excision of epulis.
- Excision of an unerupted impacted tooth, including removal of alveolar bone and sectioning tooth.
- Removal of a residual root (when performed by a dentist other than the one who extracted the tooth).
- Intraoral drainage of an acute alveolar abscess with cellulitis.
- Alveolectomy.
- Gingivectomy for gingivitis or periodontitis.

Exceptions

The following are not covered under dental:

- Services and supplies for lost or stolen dentures or appliances.
- Hospital charges, even if the admission is for dental work.
- Replacement of a bridge or denture within five (5) years following the date of its original installation unless:
 1. Replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or
 2. The bridge or denture, while in the oral cavity, has been damaged beyond repair as a result of an injury received while you are covered under this Plan.
- Replacement of a bridge or denture, at any time, when the bridge or denture meets or can be made to meet commonly held dental standards of functional acceptability.
- Appliances or restorations, except full dentures when the primary purpose is to alter vertical dimension, stabilize periodontally involved teeth, or restore occlusion.
- Veneers or similar properties of crowns and pontics placed on, or replacing teeth, except the ten upper and lower anterior teeth.
- Services and supplies excluded in the exclusions section.

10 SCHEDULE OF BENEFITS - VISION

The Schedule of Benefits is a summary of the amount of benefits available when you receive Covered Services from a Provider. Please refer to the Covered Services section for a more complete explanation of the specific vision services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Benefit Booklet including any attachments or riders.

CHOICE OF VISION CARE PROVIDER: Nothing contained in this Benefit Booklet restricts or interferes with your right to select the Vision Care Provider of your choice, but your benefits are reduced when you use a Non-Network Provider.

COVERED SERVICES

COPAYMENT/MAXIMUMS

Exam

Network
\$15 Copayment

Non-Network
Reimbursed up to \$50

Limited to one exam per Member per Calendar year.*

Prescription Lenses

\$15 Copayment

Basic Lenses (Pair)

- Single Vision Lenses
- Bifocal Lenses
- Trifocal Lenses
- Lenticular Lenses

Reimbursed up to \$50
Reimbursed up to \$70
Reimbursed up to \$90
Reimbursed up to \$110

Limited to one set of lenses per Member per Calendar year*

Frames (Limited to one set of frames per Member per Calendar year*)

Any frame up to \$120 retail

Reimbursed up to \$50

Prescription Contact Lenses

(traditional or disposable)

• **Non-Elective Contact Lenses**

No Copayment. Non-Elective Contact Lenses are reimbursed up to \$120

Non-Elective Contact Lenses are Reimbursed up to \$75

(Availability once per Calendar year *)

• **Elective Contact Lenses**

No Copayment. Elective contact lenses are reimbursed up to \$125

Elective Contact Lenses are Reimbursed up to \$125

(Availability once per Calendar year*)

* from the Last Date of Service.

Note: If you elect covered Non-Elective Contact Lenses or Elective Contact Lenses within one Calendar year, no benefits will be available for covered Lenses and frames until the next Calendar year.

11 COVERED SERVICES

This section describes the Covered Services available under your vision care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Benefit Booklet. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

The following are Covered Services:

- Routine Vision examinations
- Standard Eyeglass Lenses
- Frames
- Contact Lenses in lieu of Eyeglass Lenses

Services and materials obtained through a Non-Network Provider are subject to the same Exclusions and limitations as services through a Network Provider.

If you choose a frame that is valued at more than the Maximum Allowable Amount you are responsible for the difference in cost.

If a Member elects either covered Non-Elective or Elective Contact Lenses within one 12-month period, no benefits will be paid for covered lenses and frames until the next 12-month period.

Vision Eye Examination

The Plan covers up to a comprehensive eye examination including dilation as needed minus any applicable Copayment. The eye examination may include the following:

- Case history
- Recording corrected and uncorrected visual acuity

- Internal exam
- External exam
- Pupillary reflexes
- Binocular vision
- Objective refraction
- Subjective refraction
- Glaucoma test
- Slit lamp exam (Biomicroscopy)
- Dilation
- Color vision
- Depth perception
- Diagnosis and treatment plan.

Eyeglass Lenses

Eyeglass Lenses are available in standard or basic plastic (CR39) Lenses including single vision, bifocal, and trifocal. If you choose progressive Lenses that are no line bifocals, there will be an additional cost. All eyeglass Lenses are subject to the applicable Copayment listed in the Schedule of Benefits. There will also be an additional cost for any add-ons to the lenses such as scratch-resistant coating or ultra-violet coating. These and any other lens add-ons may be discounted according to the Plan's Additional Savings Program.

Frames

The frame allowance is based upon the retail cost. The Member may apply the plan allowance toward the Network Provider's selection of frames. The Schedule of Benefits lists the frames allowance available under your plan. If you choose a set of frames that are valued at more than the Maximum Allowable Amount, you are responsible for the balance based upon the Additional Savings Program.

Elective Contact Lenses

The contact lens allowance must be completely used at the time of initial service. No amount of the allowance may be carried forward to use during another service date. The Schedule of Benefits list the contact lens allowance available under this Plan.

Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. The Contact Lens allowance is paid toward materials first; any remaining amount will be applied to the professional fitting fee.

Non-Elective Contact Lenses

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lens or Lenses and frames benefit.

Eligibility

Conditions that provide eligibility for consideration of this Non-Elective Contact Lens benefit include:

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

Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. However, the Plan's Maximum Allowable Amount reimbursement

paid to the prescribing Provider for Non-Elective Contact Lenses may include a portion, or all, of the fitting fee. Any remaining amount will be applied to the Provider's fitting fee.

SPECIAL NOTE: The Plan will not reimburse for Non-Elective Contact Lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Cosmetic Options

Benefits are available for the services below in accordance with the Additional Savings Program. The Member will be responsible for the following items at a discounted rate when provided by a Network Provider.

- Blended Lenses
- Contact Lenses (except as noted herein)
- Oversize Lenses
- Progressive multifocal Lenses
- Photochromatic Lenses, or tinted Lenses
- Coated Lenses
- Frames that exceed the Maximum Allowable Amount
- Cosmetic Spectacle Lenses
- Ultra-violet coating
- Scratch resistant coating
- Polycarbonate Lenses
- Anti-reflective coating
- Optional cosmetic items

12 TERMINATION AND CONTINUATION

Termination

Coverage for Enrollees and Dependents will terminate on the earliest of:

- The date the Administrative Service Agreement or Plan is terminated; or
- The date the payroll deduction authorization is withdrawn; or
- The date the premiums are due and payable and unpaid; or
- Termination of employment (except when retiree coverage is elected); or
- The date a Dependent ceases to be eligible as defined.

Federal Continuation of Coverage (COBRA)

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

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the State's health Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage

must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the State's health Plan is lost because of the qualifying event. Under the State's health Plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the State for premium payment requirements.

If you are an Enrollee, you will become a qualified beneficiary if you lose your coverage under the State's health Plan because either one of the following qualifying events happens:

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

If you are the spouse of an Enrollee, you will become a qualified beneficiary if you lose your coverage under the State's health Plan because any of the following qualifying events happens:

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

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

- The parent-Enrollee dies;
- The parent-Enrollee's hours of employment are reduced;

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

If Your Plan Offers Retirement Coverage

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

When is COBRA Coverage Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the State 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 Enrollee, commencement of a proceeding in bankruptcy with respect to the State, or the Enrollee's becoming entitled to Medicare benefits (under Part A, Part B, or both), then you must notify the State of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Enrollee and spouse or a Dependent child's losing eligibility for coverage as

a Dependent child), you must notify the State within 30 days after the qualifying event occurs.

How is COBRA Coverage Provided

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

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Enrollee, the Enrollee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Enrollee's hours of employment, and the Enrollee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Enrollee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Enrollee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Enrollee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the State's health Plan is determined by the Social Security Administration to be disabled and you notify the State in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the State. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Enrollee or former Enrollee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the State's health Plan had the first qualifying event not occurred.

Fees

You must pay Fees for any period of continuation coverage. If you make the election after the qualifying event, any Fees due must be paid by 45 days after the date of the election.

Cancellation

Continuation coverage will terminate if:

1. the State ceases to provide any group health plan to its Enrollees;
2. Fees are not paid on time;
3. upon the date, after the date of continuation coverage election, the qualified beneficiary first becomes covered under another group health plan that:
 - a. does not contain any limitation regarding a pre-existing condition of the beneficiary; or
 - b. does contain a pre-existing exclusion or limitation that would apply to the beneficiary but is not applicable because of the Federal Health Insurance Portability and Accountability Act of 1996's rule on pre-existing condition clauses;
4. upon the date, after the date of continuation coverage election, a qualified beneficiary other than beneficiaries that are provided continuation of coverage under paragraph "6," under "Qualifying Events and Qualified Beneficiaries," first becomes enrolled in Medicare benefits under Title XVIII of the Social Security Act; or
5. a qualified beneficiary who was disabled under paragraph "2," under "Qualifying Events and Qualified Beneficiaries," is no longer disabled. The additional 11 months of extended continuation coverage will be terminated on the first day of the month that begins more than 30 days after the date of the final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled.

Duplicate Payment

In the event an expense incurred could be covered under more than one benefit in this Plan, the Contractor, on behalf of the State, will not duplicate payment under the various benefits available. However, consecutive payments for covered services will be provided as appropriate.

Cancellation Of The Administrative Service Agreement

The State may cancel the Plan at any time by giving advance written notice. The cancellation will not be effective before the end of the period for which the State has paid premiums, according to the Schedule of Financial Variables.

Cancellation Of Administrative Service Agreement Enrollment

If an Eligible Person makes a material misrepresentation on a claim for the Plan's benefits, the contractor, on behalf of, the State, may cancel the enrollee's Plan enrollment, effective on or anytime after the date of the claim, without giving advance notice to the enrollee. If an enrollee ceases to meet the Plan's definition of an Eligible Person or dependent, that enrollee's Plan enrollment is automatically canceled.

Cancellation of an Eligible Person's Plan enrollment ends the Eligible Person's and dependents' coverage and all rights to the Plan's benefits effective on the date of cancellation, except for any applicable extension of benefits provision. Cancellation of a dependent's Plan enrollment ends the dependent's coverage and rights to the Plan's benefits, effective on the date of cancellation, except for any applicable extension of benefits provision. An Eligible Person may cancel his or her coverage of a dependent's coverage at any time by giving advance written notice. The cancellation will be effective the end of a period for which coverage premiums have been paid.

13 HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Service from Providers; however, the broadest benefits are provided for services obtained from Network Providers. **Services you obtain from any Provider other than a Network Provider which are not an Authorized Service or Emergency Care are considered a Non-Network Service.**

Network Services and Benefits

If your care is rendered by a Network Provider benefits will be provided at the Network level. The Contractor, on behalf of the State, has final authority to determine the Medical Necessity of the service or referral to be arranged.

The Contractor, on behalf of the State, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other Facility. This decision is made upon review of your condition and treatment.

If the type of Provider is not included in the Network, contact us and we may approve a Non-Network Provider for that service as an Authorized Service. Network providers are described below:

Network Providers include Physicians, Professional Providers, Hospitals and Facility Providers who contract with us to perform services for you.

For services rendered by Network Providers:

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

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

Non-Network Services

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

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

- obtaining any Precertification which is required;
- filing claims; and
- higher cost sharing amounts, i.e., possible balance billing for any costs in excess of the covered charges

Relationship of Parties (Plan - Network Providers)

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

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

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers and Non-Network Providers and disease management

programs. If you have questions regarding such incentive or risk sharing relationships, please contact your Provider or the Contractor.

Not Liable for Provider Acts or Omissions

The Contractor and/or the Plan is not responsible for the actual care you receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Contractor and/or the Plan based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

When you receive care from a Network Provider or other Provider, you must show your Plan Identification Card. Possession of a Plan Identification Card confers no right to services or other benefits under this Plan. To be entitled to such services or benefits you must be a Enrollee on whose behalf all applicable Fees under this Plan have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Benefit Booklet you will be responsible for the actual cost of such services or benefits.

14 HEALTH CARE MANAGEMENT

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

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

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

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

Just because the Contractor exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that the Contractor will do so in the future, or will do so in the future for any other Provider, claim or

Enrollee. The Contractor may stop or modify any such exemption with or without advance notice.

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

If you have any questions regarding Health Care Management or to determine which services require Precertification, call the Precertification telephone number on the back of your Identification Card or refer to Our website, www.anthem.com.

Enrollees are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information relevant to the Enrollee's Precertification request.

Your right to benefits for Covered Services provided under this Benefit Booklet is subject to certain policies, guidelines and limitations, including, but not limited to, Our Clinical Coverage Guidelines, Medical Policy and Health Care Management features listed in this section.

Clinical Coverage Guidelines

The Contractor's clinical coverage guidelines such as medical policy, preventive care clinical coverage guidelines, Precertification review guidelines, Concurrent review guidelines, and Retrospective review guidelines, reflect the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of Clinical Coverage Guidelines is to assist in the interpretation of Medical Necessity. However, the Benefit Booklet and Administrative Services Agreement take precedence over the clinical coverage guidelines. Medical technology and standards of care are constantly changing and the Contractor, on behalf of the State, reserves the right to review and update the clinical coverage guidelines periodically.

Precertification

NOTICE: Precertification or prior authorization does NOT guarantee coverage for or the payment of the service or procedure reviewed. It is a confirmation of Medical Necessity only.

Precertification is a Health Care Management feature which requires that an approval be obtained from the Contractor, on behalf of the State, before incurring expenses for certain Covered Services. The Contractor's procedures and timeframes for making decisions for Precertification requests differ depending on when the request is received and the type of service that is the subject of the Precertification request.

Urgent Review means a review for medical care or treatment that in the opinion of the treating Provider or any Physician with knowledge of the Enrollee's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Enrollee or the ability of the Enrollee to regain maximum function, based on a prudent layperson's judgement, or, in the opinion of a Physician with knowledge of the Enrollee's medical condition, would subject the Enrollee to severe pain that cannot be adequately managed without such care or treatment. Applying the prudent layperson standard, the Contractor, on behalf of the State, may determine that an Urgent Review should be conducted. Concurrent reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay for Inpatient admissions will be determined. Medical Necessity includes a review of both the services and the setting. **For certain services you will be required to use the Provider designated by Our Health Care Management staff.** The care will be covered according to your benefits for the number of days approved unless the Concurrent review determines that the number of days should be revised. If a request is denied, the Provider may request a reconsideration. The Contractor's Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the

Enrollee's health requires an earlier decision.

Most Providers know which services require Precertification and will obtain any required Precertification. Most Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. Generally, the ordering Provider, facility or attending Physician will call to request a Precertification review ("requesting Provider"). The Contractor, on behalf of the State, will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific Precertification request. The authorized representative can be anyone who is 18 years or older. For Urgent Reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on the Contractor's process for designating an authorized representative, call the **Precertification telephone number** on the back of your Identification Card.

You are responsible for obtaining Precertification for certain services you obtain:

- **from a Non-Network Provider; or**
- **from a Network Provider through the local Blue Cross and Blue Shield Plan if you are traveling or you live outside of the Service Area.**

When it is your responsibility to obtain Precertification, you should either:

- **verify that the Non-Network or Blue Card Provider obtains the required Precertification; or**
- **obtain the required Precertification yourself.**

If you or your Non-Network or Blue Card Provider do not obtain the required Precertification, a Retrospective review will be done to determine if your care was Medically Necessary.

If the Contractor, on behalf of the State, determines the services you receive

are not Medically Necessary under your Plan and you received your care from a BlueCard Provider or a Provider that does not have a participation agreement with the Contractor, you will be financially responsible for the services.

The Blue Access Plan requires the Enrollee to use Providers participating in the Blue Access Network. If services are received from a Non-Network Provider, you will receive a 40% penalty.

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

For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Precertification Procedures

Prospective review means a review of a request for Precertification that is conducted prior to a Enrollee's Hospital admission or course of treatment. For Prospective reviews, a decision will be made and telephone notice of the decision will be provided to the requesting Provider, as soon as possible, taking into account the medical circumstances, but not later than two business days from the time the request is received by the Contractor, on behalf of the State. For Urgent reviews, telephone notice will be provided to the requesting Provider as soon as possible, taking into account the medical urgency of the situation,

but not later than two calendar days from the time the request is received by the Contractor, on behalf of the State.

If additional information is needed to certify benefits for services, the Contractor, on behalf of the State will notify the requesting Provider by telephone and send written notification to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review as soon as possible, but not later than two business days after receipt of the request. For Urgent Reviews the Contractor, on behalf of the State will notify the requesting Provider by telephone of the specific information necessary to complete the review within 24 hours after receipt of the request by the Contractor, on behalf of the State. Written notice will be sent following the request by telephone.

The requested information must be provided to the Contractor, on behalf of the State, within 45 calendar days from receipt of the Contractor's request. **Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day.** For Urgent Reviews, the requested information must be provided within 48 hours after the Contractor's request for specific information.

A decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, but not later than two business days (two calendar days for Urgent Reviews) after the Contractor's receipt of the requested information.

If a response to the Contractor's request for specific information is not received or is not complete, a decision will be made based upon the information in the Contractor's possession and telephone notice of the decision will be provided to the requesting Provider not later than two business days (two calendar days for Urgent Reviews) after the expiration of the period to submit the requested information.

Written notice of Prospective review decisions will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

Concurrent Review

Concurrent review means a review of a request for Precertification that is conducted during a Enrollee's Inpatient Hospital stay or course of treatment. As a result of Concurrent review, additional benefits may be approved for care which exceeds the benefit(s) originally authorized by the Contractor's Health Care Management staff, on behalf of the State.

If a request for Concurrent review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for Urgent Review, a decision will be made and telephone notice of the decision will be provided to the requesting provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by the Contractor. If the request is not received within 24 hours prior to the end of the approved care, the decision will be made and telephone notice of the decision will be provided to the requesting provider within two calendar days from the time the request is received by the Contractor. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

For Concurrent reviews that do not qualify for Urgent Review, the decision will be made and telephone notice will be provided to the requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the request is received by the Contractor.

If additional information is needed to certify benefits for services for a Concurrent review that does not qualify for Urgent review, the Contractor, on behalf of the State, will notify the requesting provider by telephone and will send written notice to you or your authorized representative and the requesting provider of the specific information necessary to complete the review within two business days after receipt of the request.

You or your authorized representative and the requesting provider have 45 calendar days from receipt of the Contractor's request to provide the

information to the Contractor. **Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day.** A decision will be made and telephone notice of the decision will be provided to the requesting Provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the requested information is received by the Contractor. If a response to the Contractor's request for specific information is not received or is not complete, a decision will be made based upon the information in the Contractor's possession and telephone notice of the decision will be provided to the requesting Provider(s) and written notice of the decision will be sent to you or your authorized representative and the Provider(s) not later than two business days after expiration of the period to submit the requested information.

The Contractor, on behalf of the State, will not reduce or terminate **a previously approved** on-going course of treatment until you or your authorized representative receive telephone notice of Plan's decision and have an opportunity to appeal the decision and receive notice of the appeal decision.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after health care services have been provided to a Enrollee. If Precertification is required but not obtained prior to the service being rendered, the Contractor, on behalf of the State, will conduct a Retrospective review. Further, if a service is subject to a clinical coverage guideline, but Precertification is not required for that service, the Contractor, on behalf of the State, may conduct a Retrospective Review. Retrospective review may be completed before a claim is submitted (pre-claim) or after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

For pre-claim Retrospective review, a decision will be made within two business days from the time the request is received by the Contractor. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within two business days from the time the request is received by the Contractor.

If additional information is needed to certify benefits for services, the Contractor, on behalf of the State, will notify you or your authorized representative and the requesting Provider in writing, of the specific information necessary to complete the review, within two business days after receipt of the request.

You or your authorized representative and the requesting Provider have 45 calendar days from receipt of the Contractor's request to provide the information. **Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day.**

A decision will be made within two business days from the time the requested information is received by the Contractor. If a response to the Contractor's request for specific information is not received or is not complete, a decision will be made based upon the information in the Contractor's possession not later than two business days after expiration of the period to submit the requested information.

For post-claim Retrospective Review, a decision will be made within 30 calendar days from the time the claim is received by the Contractor, on behalf of the State. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 30 calendar days from the time the claim is received by the Contractor.

If additional information is needed to certify benefits for services, the Contractor, on behalf of the State, will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within 30 calendar days after receipt of the claim.

You or your authorized representative and the

requesting Provider(s) have a reasonable amount of time taking into account the circumstances, but not less than 45 calendar days from the date of the Contractor's request to provide the additional information. A decision will be made within 15 calendar days from the time the requested information is received by the Contractor. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 15 calendar days of receiving the requested information.

Case Management (includes Discharge Planning)

Case Management is a Health Care Management feature designed to assure that your care is provided in the most appropriate and cost effective care setting. This feature allows the Contractor, on behalf of the State, to customize your benefits by approving otherwise non-covered services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Contractor's Health Care Management staff, on behalf of the State. In managing your care, the Contractor, on behalf of the State, has the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

15 EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide benefits for procedures, equipment, services, supplies or charges:

1. For: (1) artificial insemination; (2) in vitro fertilization; (3) embryo transfer; (4) sterilization reversal; (5) gamete intra fallopian transfer (GIFT); (6) gender change; (7) any other fertility or infertility treatment; or (8) improving or restoring sexual function.
2. Related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
3. For artificial heart implants.
4. For animal organ or artificial organ transplants.
5. For eyeglasses, contact lenses, or examinations to prescribe or fit such items (eye refractions), except that the cost of the first pair of either eyeglasses, contact lenses, or intraocular lenses required following cataract surgery is not excluded.
6. For hearing aids, devices, or implants, or for the examination for their prescription and fitting.
7. Which the Plan determines are not Medically Necessary.
8. For Custodial Care which is care that primarily meets personal rather than medical needs and which can be provided by persons with no special medical skills or training.
9. For standby charges of a Physician.
10. For dental, except as specifically stated in this Certificate.
11. For private duty nursing services except when provided through the Plan's home health care benefit.
12. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Plan.
13. For treatment and care connected with or incidental to treatment, that is intended primarily to improve personal appearance. Benefits will be provided for care and treatment intended to restore bodily function or correct deformity resulting from disease, accidental injury, birth defects, or previous therapeutic process.
14. For 1) Care of flat feet; 2) supportive devices of the foot, (unless specifically made for and fitted to a particular individual; 3) care of corns, bunions, or calluses; 4) care of toenails; and 5) care of fallen arches, weak feet, or chronic foot strain, except that 3) and 4) are not excluded when medically necessary because the enrollee or covered dependent is diabetic or suffers from circulatory problems.
15. For occupational accidents and diseases which are or could have been paid for or available under the requirements of Worker's Compensation and Occupational Disease Law. This exclusion does not apply if the enrollee is not eligible for Worker's Compensation benefits.

16. For research studies or screening examinations, except as specifically stated in this Certificate.
17. Used to treat conditions related to hyperkinetic syndromes, behavioral problems, mental retardation or senile deterioration, beyond the period necessary to diagnose the condition.
18. Provided for, or in connection with, care or treatment of any illness or injury due to war or any act of war. "War" includes armed aggression resisted by the armed forces of any country, combination of countries, or international organization, whether or not war is declared.
19. To the extent the enrollee has no legal obligation to pay for.
20. Incurred before an Enrollee's coverage under the plan becomes effective or after it ends, except as specifically stated elsewhere in this Plan.
21. Provided by a sanitarium, or rest cures.
22. Furnished by any person or institution acting beyond the scope of his/her/its license.
23. For Plan benefits to the extent that the services are a Medicare Part A or Part B liability.
24. Received from a dental or medical department maintained by or on behalf of a State, a mutual benefit association, labor union, trust, or similar person or group.
25. Provided by any governmental agency to the extent provided without cost to the enrollee except as this exclusion may conflict with federal or state law.
26. For travel, whether or not recommended by a physician.
27. If the Plan does not state that benefits are provided for them.
28. For: telephone consultations, charges for failure to keep a scheduled visit, completing attending physician's statements or claim forms, or other services not part of the direct medical care of the patient.
29. For recreation or diversional therapy.
30. For hospitalization for environmental change or provider individual charges connected with prescribing an environmental change.
31. For temporomandibular Joint (TMJ) Syndrome, except as specifically stated in this Certificate.
32. For personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a physician.
33. Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reason are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
34. Services or supplies used to treat conditions related to autism.
35. For speech therapy, except when received as a result of congenital anomalies or following an accident, stroke or surgery or disease.
36. For dental services or supplies that is necessary because a denture or orthodontic appliance was lost or stolen.
37. For dental sealants for patients age nineteen (19) or over.
38. For dental sealants other than for posterior teeth.
39. For durable medical equipment which benefits others in the enrollee's household, other than the patient, even when prescribed by a physician.

40. Used to treat an enrollee or covered dependent who becomes sick or injured due to: participating in a riot, civil disturbance, or street violence; or committing or attempting to commit an assault or a felony.
41. Provided primarily for educational, vocation, or training purposes.
42. For radial Keratotomy or for kertomileusis.
43. For treatment in any facility which is mainly a place for: rest, convalescence, custodial care, the aged, rehabilitation, training, schooling or occupational therapy.
44. For environmental control equipment and modifications to the home, property or equipment.
45. For physical exams and immunizations required for enrollment in any insurance program, as a condition of employment or for licensing are not covered.
46. For which claims are not timely filed, according to this Certificate's claim filing provisions.
47. For appliances, restorations or procedures for the purpose of splinting or implantology, or to alter vertical dimension or restore occlusion.
48. For veneers or similar properties of crowns or pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth.
49. For replacement of a lost, missing, or stolen dental prosthetic device.
50. For replacement or repair of an orthodontic appliance.
51. For dental prosthetic devices, (including bridges and crowns) and fitting thereof, which were ordered while the individual was covered under this Plan, but which are finally delivered or installed more than 60 days after termination of coverage.
52. For anything not furnished by a physician, except X-rays ordered by a dentist, and services by a licensed dental hygienist under the dentist's supervision.
53. For expenses applied toward satisfaction of a deductible under this dental exhibit.
54. For facings on molar crowns or pontics or any other services for cosmetic purposes unless made necessary by an accident occurring while covered.
55. For replacement or modification of a crown, gold restoration, denture, or fixed bridge, or addition of teeth to the denture or bridge, if the initial dental work was performed less than five (5) years before the current service.
56. For prescription drugs dispensed from a pharmacy with the intent of home administration or consumption. These claims are to be filed with the prescription drug carrier.
57. For duplication of X-rays.
58. For sterilization of dental appliances.
59. For bleaching.
60. For applying desensitizing medication.
61. For take home fluoride.
62. For initial installation of a denture or bridgework to replace teeth the enrollee lost before the effective date of this dental plan.
63. For periodontal splinting.
64. For oral care instructions, for example, hygiene or diet.
65. For dental services and supplies primarily for cosmetic or esthetic purposes.
66. For plaque control programs, oral hygiene and dietary instructions.
67. For dental prosthetics.
68. Related to extra sets of dentures or other devices or appliances.
69. For dental appliances (for example, night guards) used to correct harmful habits.
70. For dental bonding.

71. In excess of the Maximum Allowable Amount.
72. In a skilled nursing facility (Inpatient or Outpatient).
73. For hospice care.
74. For wigs and artificial hair except as specifically stated in the plan's benefits.
75. For a denture or fixed bridge involving replacement of teeth extracted before the patient was covered under this Plan, unless: the denture or fixed bridge replaces a tooth that was extracted while the patient was covered under this plan; and such tooth was not an abutment for a denture or fixed bridge installed during the preceding five (5) years.
76. For: a) the care and treatment of the teeth, gum or alveolar process, except as specifically provided for under this Plan, b) dentures, appliances or supplies used in such care and treatment unless such expenses are incurred as a result of an accident which occurred while the Enrollee was receiving coverage under this Plan.
77. For an appliance, or modification of one, where an impression was made before the patient was covered under this Plan; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered under this Plan; or root canal therapy if the pulp chamber was opened before the patient was covered under this Plan.
78. If you change dentists during the treatment program, the benefits provided will be the same as if only one dentist had performed treatment.

16 CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Therefore, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply, unless the claim was not filed by the Provider.

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim use a claim form.

Maximum Allowed Amount

General

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

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

- that meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under your Plan 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 Benefit 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 Non-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from Provider, the Contractor 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 the Contractor's determination of the Maximum Allowed Amount. The Contractor's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Contractor has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

Provider Network Status

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

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

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

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

1. An amount based on the Contractor's Non-Network Provider fee schedule/rate, which the Contractor has established in its' discretion, and which the Contractor reserves 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 the Contractor, 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, the Contractor 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 the Contractor or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Non-Network Provider.

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

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

Customer Service is also available to assist You in determining this/your Plan's Maximum Allowed Amount for a particular service from a Non-Network Provider. In order for the Contractor 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 the Contractor using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

Member Cost Share

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

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

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

In some instances You may only be asked to pay the lower Network cost sharing amount when You use a Non-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from a Non-Network

Provider such as a radiologist, anesthesiologist or pathologist who is not employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Benefit 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 Network services, and 30% for Non-Network services after the Network or Non-Network Deductible has been met.

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

- *The Non-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; Your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from the Plan is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total Out of Pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*
- *You choose a Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; Your Coinsurance responsibility when a Network surgeon is used is 20% of \$1500, or \$300. The Plan allows 80% of \$1500, or \$1200. The Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.*
- *You choose a **NON-NETWORK** surgeon. The Non-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; Your Coinsurance*

responsibility for the NON-NETWORK surgeon is 30% of \$1500, or \$450 after the NON-NETWORK Deductible has been met. The Plan allows the remaining 70% of \$1500, or \$1050. **In addition**, the Non-Network surgeon could bill You the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.

Authorized Services

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

The following are examples for illustrative purposes only; the amounts shown may be different than this Benefit 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 Network Provider for that specialty in your state of residence. You contact the Contractor in advance of receiving any Covered Services, and the Plan authorizes You to go to an available Non-Network Provider for that Covered Service and the Plan agrees that the Network cost share will apply.

Your plan has a \$45 Copayment for Non-Network

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

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

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

Services Performed During Same Session

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

Payment of Benefits

You authorize the Contractor, on behalf of the State, to make payments directly to Providers for Covered Services. The Contractor, on behalf of the State, also reserves the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Contractor, on behalf of the State, will discharge the State's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified

Medical Child Support order” as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, the Contractor, on behalf of the State, will not honor a request to withhold payment of the claims submitted.

Assignment

The coverage and any benefits under this Plan are not assignable by any Enrollee without the written consent of the Plan, except as provided above.

Notice of Claim

The State is not liable under the Plan, unless the Contractor receives written notice that Covered Services have been given to you. The notice must be given to the Contractor, on behalf of the State, within 90 days of receiving the Covered Services, and must have the data the Contractor needs to determine benefits. If the notice submitted does not include sufficient data the Contractor needs to process the claim, then the necessary data must be submitted to the Contractor within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

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

Failure to give the Contractor notice within 90 days will not reduce any benefit if you show

that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later December 31 of the year following the year the service was received, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to the Contractor and/or the State or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to the Contractor, on behalf of the State, 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 Enrollee
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Proof of Claim

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

Time Benefits Payable

The Plan 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 the Contractor has not received the information it needs to process a claim, the Contractor, on behalf of the State, will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, the Contractor cannot complete the processing of the claim until the additional information requested has been received. The Plan generally will make its request for additional information within 30 days of the initial receipt of the claim and will complete the processing of the claim within 15 days after the receipt of all requested information.

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

Your Choice of Providers

- The choice of a Provider is solely yours.
- The Plan does not furnish Covered Services but only pays for Covered Services you receive. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to give Covered Services to you.

Enrollee's Cooperation

Each Enrollee shall complete and submit to the Contractor, on behalf of the State, such authorizations, consents, releases, assignments and other documents as may be requested by the Contractor in order to obtain or assure reimbursement under Medicare, Worker's

Compensation or any other governmental program.

Explanation of Benefits

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

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

BlueCard

When you obtain health care services through BlueCard outside the geographic area the Contractor serves, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto the Contractor, on behalf of the State.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any contingent payment arrangements, and non-claims transactions with your health care Provider or with a specified group of Providers. The

negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Enrollee liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Enrollee liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Contractor, on behalf of the State, would then calculate your liability for any Covered Services in accordance with the applicable state statutes in effect at the time you received your care.

17 GENERAL PROVISIONS

Entire Administrative Service Agreement

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

Form or Content of Benefit Booklet

No agent or employee of the Plan is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

Disagreement With Recommended Treatment

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

judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Network Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Network Provider, shall have any further responsibility to provide care for the condition under treatment or any complications thereof. The continued refusal by you to follow the recommended treatment or procedure(s) may result in termination of your coverage.

Circumstances Beyond the Control of the Plan

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

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of

certain individually identifiable health information. The State's Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the State's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As a Contrator of the State's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the customer service number on the back of your Identification Card.

Coordination Of Benefits

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

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit 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 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 the Plan's 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 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 the Contractor has 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 this Plan's Benefits

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. The Contractor, on behalf of the Employer, may get the facts it needs 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. The Contractor need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Contractor any facts the Contractor 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, This Plan 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. This Plan 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 This Plan is more than should have paid under this COB provision, the Contractor, on behalf of the Employer, may recover the excess from one or more of the persons:

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

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

Medicare

Any benefits covered under both this Benefit Booklet and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Benefit Booklet provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Benefit Booklet for Enrollees age 65 and older, or Enrollees otherwise eligible for Medicare, do not duplicate any benefit for which Enrollees are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Enrollees shall be reimbursed by or on behalf of the Enrollee to the Plan, to the extent the Plan has made payment for such services.

Physical Examination

The Contractor, on behalf of the State, reserves the right to cause you to be examined by an applicable Provider as often as may be reasonably required during the pendency of a claim.

Worker's Compensation

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

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Benefit Booklet shall not duplicate any benefits to which Enrollees are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Enrollees shall be paid by or on behalf of the Enrollee to the Plan.

Subrogation/Reimbursement

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

Subrogation

Contractor, on behalf of State have the right to recover payments the Plan makes on your behalf from any party responsible for compensating you for your injuries. The following apply:

- Plan has the first priority for the full amount of benefits it was 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 the State to exercise its rights and do nothing to prejudice them.
- The Contractor, on behalf of the State, has the right to take whatever legal action it sees 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 the State's subrogation claim and any claim still held by you, the State's subrogation claim shall be first satisfied before any part of a Recovery is applied to

your claim, your attorney fees, other expenses or costs.

- The State is not responsible for any attorney fees, other expenses or costs without its prior written consent. The State further agrees 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 the Plan.

Reimbursement

If you obtain a Recovery and the State has not been repaid for the benefits paid on your behalf, the State 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 the Plan to the extent of benefits paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the State shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the State 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 the State immediately upon your receipt of the Recovery. you must reimburse the State, 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 the State.
- If you fail to repay the State, it shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the State; or
 2. you fail to cooperate.
- In the event that you fail to disclose to the State the amount of your settlement, the Plan shall be entitled to deduct the amount of its lien from any future benefit under the Plan.
 - The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan have paid or the amount of your settlement, whichever is less, directly from the providers to whom the Plan have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the Plan would not have any obligation to pay the provider.
 - The Plan 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 the Contractor, on behalf of the State 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 the Contractor in the investigation, settlement and protection of the State's rights.
- You must not do anything to prejudice the State's rights.
- You must send the Contractor 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.

Relationship of Parties (State-Enrollee-Plan)

Neither the State nor any Enrollee is the agent or representative of the Plan.

The State is the fiduciary agent of the Enrollee. The Plan's notice to the State will constitute effective notice to the Enrollee. It is the State's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Enrollees if the State fails to provide the Plan with timely notification of Enrollee enrollments or terminations.

Anthem Insurance Companies, Inc. Note

The State, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this policy constitutes an Administrative Service Agreement solely between the State and Anthem Insurance Companies, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Notice

Any notice required under this Benefit Booklet may be given by United States Mail, First Class, Postage Paid, addressed as follows:

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

Or, if to a Enrollee, at the last address known to the Plan.

Modifications

By this Benefit Booklet, the State makes the Plan coverage available to eligible Enrollees. However, this Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Administrative Service Agreement, or by mutual agreement between the Plan and the State without the consent or concurrence of any Enrollee. By electing medical and hospital coverage under the Plan or accepting the Plan benefits, all Enrollees legally capable of contracting and the legal representatives of all Enrollees incapable of contracting agree to all terms, conditions, and provisions hereof.

Conformity with Law

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

Clerical Error

Clerical error, whether of the State or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this

Benefit Booklet with which a Enrollee shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Benefit Booklet, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

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

Provider Reimbursement

Benefits shown in this Benefit Booklet or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with the Contractor.

Providers who have a reimbursement agreement with the Contractor have agreed to accept either the Maximum Allowable Amount allowance or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with the Contractor will normally bill you for amounts the Contractor, on behalf of the State, considers to exceed the Maximum Allowable Amount in addition to any Deductibles, Coinsurance and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with the Contractor, your payment obligations for Deductibles, Coinsurance and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your Payment Maximum mean the amounts actually paid by the Contractor, on behalf of the State, for services received from a Provider which does not have a reimbursement agreement with the Contractor or the amount for which you are given credit by a Provider which has a reimbursement agreement with the Contractor.

Fees

Amounts due the Contractor from the State are payable in accordance with the contract.

Not Liable For Provider Acts Or Omissions

Neither the Contractor nor the State is responsible for the quality of care an Enrollee receives from any person. The plan does not give anyone any claim, right or cause of action against the Contractor or the State based on what a provider of health care or supplies does or does not do.

Incontestability

The State may declare an Enrollee's coverage null, or cancel it, if the application to establish it or to change it contains a material misrepresentation. However, unless the material misrepresentation is contained in a written document signed by the Enrollee, this paragraph will not apply more than two (2) years after the Enrollee's coverage has been in force or the request for change in the Enrollee's coverage was made.

Legal Action

No legal action to obtain the Plan's benefits may be taken prior to 60 days after the contractor received the claim, or later than three (3) years after the date the claim is required to be furnished to the Contractor.

18 YOUR RIGHT TO APPEAL

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure the Contractor will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Contractor’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Contractor’s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;

- a description of the plan’s review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the Contractor’s notice will also include a description of the applicable urgent/concurrent review process; and
- the Contractor may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The

Contractor's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Contractor shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Contractor to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Contractor's decision, can be sent between the Contractor and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Contractor at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, , P.O. Box 105568; Atlanta, GA 30348-5568.

You must include Your Member Identification Number when submitting an appeal.

Upon request, the Contractor will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

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

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the Contractor considers your appeal, the Contractor will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A

voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Contractor will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Contractor will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Contractor will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Contractor will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Contractor within four (4) months of the notice of your final internal adverse determination.

A request for a External Review must be in writing unless the Contractor determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Contractor's decision, can be sent between the Contractor and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Contractor at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;

- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Contractor determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, , P.O. Box 105568; Atlanta, GA 30348-5568.

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent

External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

19 Medicare Carve-Out Overview

Words to know:

- Assignment - This means a doctor or supplier agrees to accept the Medicare-approved amount as full payment. It can save you money if your doctor accepts assignment. You will still pay your share of the cost of the doctor's visit.
- Participating - A Provider who has entered into a contractual agreement with Anthem regarding payment for Covered Services.
- Usual & Customary (U&C) - The Maximum Allowable Amount that Anthem determines is the maximum payable for Covered Services.

Steps for figuring Medicare Carve-Out method of payment:

1. Figure the Anthem would-pay amount (Anthem benefits if primary.)

2. Figure Benefits minus Benefits - Subtract the Medicare paid from the Anthem would-pay figure you came up with in #1. If it comes out to be a negative amount, use \$0 as this figure.
3. Figure the amount owed to the Provider after Medicare payment (i.e., the most the Provider is entitled to or allowed to bill):
 - a. Medicare Assigned claim = Medicare allowed minus Medicare paid
 - b. Medicare Non-assigned claim = Take 115% of the Medicare allowed (or use the 115% figure if given) and subtract the Medicare paid
4. Compare the figures you calculated in #2 and #3 and pay the lesser amount.

Rationale: Anthem will pay Benefits minus Benefits figure unless doing so causes Anthem to overpay the Provider - (i.e., Anthem cannot pay the Provider more than he is legally entitled to collect or bill (i.e., the Medicare allowed amount or 115% thereof, if a non-assigned claim.) All group insurance and Medicare payments together may not exceed this amount.

20 Medicare Carve-Out Method of Payment Claim Examples

Example #1: Professional surgery claim with a \$2,000 total charge. Medicare allows \$1,500 in each below scenario and pays \$1,200, and claim is assigned. Provider is Participating with Anthem for 1A, 1B, and 1C. Anthem Deductible has already been satisfied.

Claim Scenario Carve-Out Calculation

1A. Anthem Maximum Allowable Amount = \$1,600 (most common scenario)

1. Anthem would pay \$1,440 if primary ($\$1,600 \times 90\%$)
2. Anthem benefits \$1,440 minus Medicare benefit. $\$1,200 = \240 difference.
3. Maximum owed Provider = \$300
4. Anthem pays lessor of 2 & 3 = \$240

Member liability = \$60

1B. Anthem Maximum Allowable Amount = \$2,000

1. Anthem would pay \$1,800 if primary ($\$2,000 \times 90\%$)
2. Anthem benefits \$1,800 minus Medicare benefit. $\$1,200 = \600 difference.
3. Maximum owed Provider = \$300
4. Anthem pays lessor of 2 & 3 = \$300

Member liability = \$0

1C. Anthem Maximum Allowable Amount = \$1,100 (rare scenario)

1. Anthem would pay \$990 if primary ($\$1,100 \times 90\%$)
2. Anthem benefits \$990 minus Medicare benefit. $\$1,200 = -\0 difference, so use \$0 as this figure.
3. Amount owed Provider = \$0 however, because Anthem Maximum Allowed Amount is only \$1,100
4. Anthem pays lessor of 2 & 3 = \$0

Member liability = \$300 - Anthem cannot force the Provider to write off the Medicare coinsurance.

1D. Anthem Maximum Allowable Amount = ???, but Provider is Non-Par with Anthem. (Anthem Maximum Allowed Amount is irrelevant; the allowed charge becomes Medicare's allowed amount.)

1. Anthem would pay \$1,350 if primary ($\$1,500 \times 90\%$)
2. Anthem benefits \$1,350 minus Medicare benefit. $\$1,200 = \150 difference.
3. Maximum owed Provider = \$300
4. Anthem pays lessor of 2 & 3 = \$150

Member liability = \$150

Example #2: Professional Surgery Claim with a \$2,000 total charge. Medicare allows \$1,500 and pays \$1,200, & claim is Non-assigned. However, Provider is Participating with Anthem. The total the provider may collect is 115% of \$1,500 = \$1,725, so the Maximum owed provider after Medicare payment = \$525. However, since providers are Participating, they are still limited to collecting only the Anthem allowed amount under Carve-Out scenarios. Anthem deductible has already been satisfied.

Claim Scenario Carve-Out Calculation

2A. Anthem Maximum Allowable Amount = \$1,600 (most common scenario)

1. Anthem would pay \$1,440 if primary ($\$1,600 \times 90\%$)
2. Anthem benefits \$1,440 minus Medicare benefit. $\$1,200 = \240 difference.
3. Maximum owed Provider = \$525 ($\$1,725 - \$1,200$)
4. Anthem pays lessor of 2 & 3 = \$240

Member liability = \$285 - this is \$60 coinsurance and \$225 is the 115%.

2B. Anthem Maximum Allowable Amount = \$2,000 (however, the Provider may not collect more than \$1,725)

1. Anthem would pay \$1,552.50 if primary ($\$1,725 \times 90\%$)
2. Anthem benefits \$1,552.50 minus Medicare benefit. $\$1,200 = \352.50 difference.
3. Maximum owed Provider = \$525
4. Anthem pays lessor of 2 & 3 = \$352.50

Member liability = \$172.50

2C. Anthem Maximum Allowable Amount = \$1,100 (rare scenario)

1. Anthem would pay \$990 if primary ($\$1,100 \times 90\%$)
2. Anthem benefits \$990 minus Medicare benefit. $\$1,200 = \210 difference, so use \$0 as this figure.
3. Amount owed Provider = \$525 however, because Anthem's allowed amount is less, member can still be held liable for coinsurance and 115%)
4. Anthem pays lessor of 2 & 3 = \$0

Member liability = \$525

Example #3: Professional Surgery Claim with a \$2,000 total charge. Medicare allows \$1,500 and pays \$1,200, & claim is Non-assigned. Provider is also Non-Participating with Anthem. The total the provider may collect is 115% of \$1,500 = \$1,725, so the Maximum owed provider after Medicare payment = \$525. Anthem deductible has already been satisfied.

Claim Scenario Carve-Out Calculation

3A, 3B & 3C Anthem Maximum Allowable Amount is irrelevant; the Maximum Allowable charge becomes 115% of Medicare's approved amount = \$1,725.

1. Anthem would pay \$1,552.50 if primary ($\$1,725 \times 90\%$)
2. Anthem benefits \$1,552.50 minus Medicare benefit. $\$1,200 = \352.50 difference.
3. Maximum owed Provider = \$525
4. Anthem pays lessor of 2 & 3 = \$352.50

Member liability = \$172.50

This would be a very rare scenario.

Example #4: Inpatient Facility Claim with a \$10,000 total charge. Medicare allows \$7,500 in each below scenario and pays \$6,688, & claim is assigned. Anthem deductible has already been satisfied.

Claim Scenario Carve-Out Calculation

4A. Anthem allowed = \$8,500 al-
 1. Anthem would pay \$7,650 if primary (\$8,500 X 90%)
 2. Anthem benefits \$7,650 minus Medicare benefit. \$6,688 = \$962 difference.
 3. Maximum owed Provider = \$812
 4. Anthem pays lessor of 2 & 3 = \$812
 Member liability = \$0

4B. Anthem allowed = \$9,500 al-
 1. Anthem would pay \$8,550 if primary (\$9,500 X 90%)
 2. Anthem benefits \$8,550 minus Medicare benefit. \$6,688 = \$1,862 difference.
 3. Maximum owed Provider = \$812
 4. Anthem pays lessor of 2 & 3 = \$812
 Member liability = \$0

4C. Anthem allowed \$7,500 al-
 1. Anthem would pay \$6,750 if primary (\$7,500 X 90%)
 2. Anthem benefits \$6,750 minus Medicare benefit. \$6,688 = \$62 difference, so use \$0 as this figure.
 3. Maximum owed Provider = \$812
 4. Anthem pays lessor of 2 & 3 = \$62
 Member liability = \$750

Example #5: Radiology Claim with a \$1574 total charge. Medicare allows \$796 and pays \$636.80, & claim is assigned. Anthem deductible has NOT been satisfied.

Claim Scenario Carve-Out Calculation

5. Anthem Maximum Allowable Amount = \$296 al-
 1. Anthem would pay \$0 if primary (applied to Deductible)
 2. Anthem benefits \$0 minus Medicare benefit. \$636.80 = \$636.80 difference.
 3. Maximum owed Provider = \$159.20
 4. Anthem pays lessor of 2 & 3 = \$0
 Member liability = \$159.20

Example #6: Office Visit Claim with a \$160 total charge. Medicare allows \$95.12 and pays \$76.10, & claim is assigned. Anthem deductible has already been satisfied.

Claim Scenario Carve-Out Calculation

- | | |
|--|--|
| 6. Anthem Maximum Allowable Amount = \$95.69 | 1. Anthem would pay \$86.20 if primary ($\$95.79 \times 90\%$)
2. Anthem benefits \$86.20 minus Medicare benefit. $\$76.10 = \10.10 difference.
3. Maximum owed Provider = \$19.02
4. Anthem pays lessor of 2 & 3 = \$10.10 |
|--|--|

Member liability = \$8.92

21 CUSTOMER SERVICE INFORMATION

**FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENTS, OR BILLINGS
CALL YOUR CUSTOMER SERVICE REPRESENTATIVES**

FOR MEDICAL and PHARMACY QUESTIONS

1-877-814-9709

TDD – 1-800-475-5462

FOR THE PRECERTIFICATION PROGRAM UNIT

1-877-814-4803

PHARMACIST HELP DESK

1-800-662-0210

FOR QUESTIONS REGARDING DENTAL OR VISION

1-800-828-3677

CLAIMS MAILING ADDRESS

Anthem Insurance Companies, Inc.

PO Box 37010

Louisville, KY 40233-7010

PLEASE HAVE YOUR IDENTIFICATION NUMBER READY WHEN YOU CALL

**HOW CAN YOU FIND OUT IF YOUR PROVIDERS ARE PART OF THE BLUE ACCESS
NETWORK?**

**Ask your physician or hospital if they are part of the Blue Access Network, contact
Customer Service or visit us on the Web at www.anthem.com.**

This booklet is for educational purposes only and it is not intended to serve as legal interpretation of benefits. Reasonable effort is made to have this booklet represent the intent of the plan language. However, the plan language stands alone and is not considered as supplemented or amended in any way by the explanations of examples included in this booklet.

Anthem Insurance Companies, Inc. provides administrative claims payment services only, and does not assume financial risk or obligation with respect to claims.

AICBL-HMOSTIN02 LUG

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
An independent licensee of the Blue Cross and Blue Shield Association.
© Registered marks Blue Cross and Blue Shield Association.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Group Name: Indiana State Police

Group Identification Number:

Subgroup Identification Number:

Mail to group.

Indiana State Police