BLUE CHOICE©

CERTIFICATE OF COVERAGE

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.

Translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your id card or in your Certificate of Coverage.

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IMPORTANT NOTICE ABOUT YOUR PROVIDER NETWORK AND BENEFITS:

There are hospitals, health care facilities, physicians or other health care providers that are not included in this plan's network. Your financial responsibilities for payment of covered services, including "cost shares," such as coinsurance, copayments, and out of pocket maximums may be higher if you use a non-network provider. Additionally, you may have some cost-sharing for preventive benefits if you do not use a network provider. Please refer to the online provider directory available at Anthem.com to determine if a particular provider is in the network, or contact customer service for assistance.

Network Directory

Information about Network Providers is available in the online network directory at www.anthem.com. You can find information such as the Provider's location and qualifications. If you don't have access to the website or need help to find a doctor who is right for you, call the Member services number on your ID card. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with Member needs.

Introduction

This Certificate contains information that you need to know about your Blue Choice Preferred Provider Organization (PPO) coverage from Anthem Blue Cross and Blue Shield (Anthem BCBS). You are urged to read this Certificate of Coverage carefully.

The terms WE, US and OUR in this Contract refer to Anthem Blue Cross and Blue Shield and its designated affiliates. When we use the term YOU or YOUR, we are talking about the subscriber and all dependents whom we accept for coverage under this Contract.

This Certificate of Coverage explains how your Blue Choice plan works. It explains the terms, Benefits, conditions, exclusions, and limitations of your coverage. It also includes information about eligibility requirements, enrollment for Benefits, claim procedures, and termination provisions.

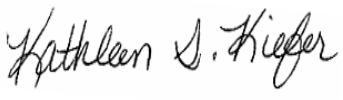
The Benefits described in this Certificate of Coverage are interpreted and administered according to the provisions and limitations herein. If there are coverage questions, Anthem BCBS will base all decisions on the provisions in this Certificate of Coverage.

The Certificate of Coverage, any Amendments or attached papers, the Schedule of Benefits, the Group application, the Group Agreement, and your individual application make up your Group Contract and your complete coverage with Anthem BCBS for health care Benefits. This Certificate of Coverage replaces any previous Certificates of Coverage you may have received.

Paying Subscription Charges and Renewal

Coverage is provided as stated in the Group Agreement. The coverage will renew automatically from year to year on the Anniversary/Renewal Date for additional one-year terms unless the Group or Anthem Blue Cross and Blue Shield gives written notice of termination, subject to the provisions in the Group Agreement.

Payment for subscription charges is due the first day of each month. If payment is received within 31 days of the due date - - the grace period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect premiums for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.



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Kathleen S. Kiefer
Corporate Secretary
Anthem Blue Cross and Blue Shield
2 Gannett Drive
South Portland, ME 04106-6911

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Claims Information
For questions about Covered Services or claims, please call a Customer Service Representative at the number on your ID card. Be sure to have your identification number ready when you call so we can answer your questions promptly.

Member Rights and Responsibilities

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

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - our company and services.
    - our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your 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. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.
- Get help at any time, by contacting your local insurance department.

  Phone: (800) 300-5000
  Write: Bureau of Insurance Department of Professional and Financial Regulation
  #34 State House Station
  Augusta, ME 04333-0034

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.

- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our Member Service department know if you have any changes to your name, address or family members covered under your plan.

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

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

How to Obtain Language Assistance

We are committed to communicating with our members about their health plan, regardless of their language. We employ a Language Line interpretation service for use by all of our Customer Service Call Centers. Simply call the Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

Section One
Eligibility, Termination, and Continuation of Coverage

Eligibility

Beginning Coverage
Before your coverage begins we must accept the Group's application, your application, and payment for your coverage. The Contract Holder acts as your remitting agent and is responsible for sending us all applications and payments for coverage, as well as notifying the Subscriber of any changes in payroll deductions for coverage, rate changes, changes in this Contract or in any documents that comprise the Contract, or termination of the Contract or your coverage under the Group Contract.

Paying Subscription Charges
Payment for Subscription Charges is due the first day of each month of coverage. To keep this coverage in effect, your Contract Holder must pay the Subscription Charges when due. If payment is received within 31 days of the due date - - the Grace Period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the Grace Period. We reserve the right to take necessary action to collect premiums for the Grace Period.

Who is an Eligible Group Member?
1. The Subscriber;
2. The Subscriber's legal spouse (For information on spousal eligibility please contact the Group);
3. The Subscriber's/spouse's children under age 26:
   a. Newborn children
   b. Biological Children, adopted children or children placed for adoption, stepchildren or legally placed foster children who live with the Subscriber or children for which the Subscriber is a legal guardian;
4. The Subscriber's/spouse's unmarried children aged 26 and older if they are mentally or physically disabled. The disability must have begun before the child's 26th birthday, and the child must have been covered by us on and continuously since his or her 26th birthday.
5. The Subscriber's grandchild under age 26, living with the Subscriber in a parent-child relationship and primarily supported by the Subscriber. The Subscriber may not enroll a child and grandchild at the same time under the same identification/policy number. The eligible child or grandchild may be covered under a separate identification/policy number.

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

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

Please note: Spouses of married dependent children are not eligible for coverage.

We will determine the effective date of coverage for the Subscriber and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call us.

We reserve the right to verify continued eligibility for all Members.

Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for medical coverage as stated in the order. A Qualified Medical Child Support Order is a judgment, decree, or order issued by a court of law which:

- Specifies your name and last known address;
- Specifies the child's name and last known address;
- Provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- States the period of time to which it applies; and
- Specifies each plan to which it applies.

A Qualified Medical Child Support Order may not require health care coverage that is not already included under the Plan.

Membership Additions

If you wish to add eligible family members after we have accepted your application, you must:

- Notify the Contract Holder;
- File an application; and
- Pay the applicable Subscription Charge.

In most cases, the effective date of coverage for added family members will not be the same as your effective date of coverage. The Contract Holder can tell you when enrollment for added family members is allowed under this Group Contract.

Family members who are eligible because of birth, adoption, marriage, court order, or dependent losing eligibility under other coverage after the Subscriber's effective date of coverage may be added as follows:

Birth A newborn is automatically covered for 31 days from the moment of its birth unless the Subscriber notifies us that the child will not be covered under the Contract. For coverage beyond 31 days, if we receive a completed application for change:

- **Within 31 days from the date of birth**, coverage is continuous from the moment of birth. We will collect applicable charges.
- **After 31 days from the date of birth**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

Adoption If we receive an adopted child's application for change:

- **Within 31 days from the date the child is adopted or placed for adoption with the Subscriber and/or spouse**, coverage will begin on the date of placement. We will collect applicable charges. If a child placed for adoption is not adopted, all health care coverage will cease when placement ends. No continuation provisions will apply.
- **After 31 days from the date the child is adopted or placed for adoption with the Subscriber and/or spouse**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

Marriage When the Subscriber marries, if we receive the spouse's (and children's, if applicable) completed application for change:

- **Within 31 days from the date of marriage**, coverage begins the first of the month that occurs immediately on or after the date we receive the application.
- **After 31 days from the date of marriage**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

Court Order Changing Custody When a court order is issued changing custody of a Dependent child, if we receive the application for change:

- **Within 31 days of the date of the court order**, coverage will begin on the date of the court order.
- **After 31 days from the date of the court order**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

Dependent Losing Eligibility Under Other Coverage When a dependent with other coverage loses that coverage, if we receive the application for change:

- **Within 31 days of the date the dependent loses coverage**, coverage will begin on the date of application for enrollment.
- **After 31 days from the date of the court order**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

If the eligible individual is not already enrolled or is enrolled in a different benefit package, the individual may enroll during this period.

Annual Late Enrollee Enrollment Period After the initial eligibility date, applications may be submitted during the annual Late Enrollee Enrollment Period agreed to by us and your employer.

Late Enrollee A Late Enrollee is a Subscriber or a Dependent family member who requests enrollment under the Contract Holder's Group health plan following the initial Enrollment Period provided under the terms of the plan; or a Subscriber or Dependent family member who enrolls after 31 days following any of the life events described below. A Late Enrollee may only submit an application during the annual Late Enrollee Enrollment.

Exception for Late Enrollees A person is not considered a Late Enrollee if he/she incurs a claim under a prior contract or policy that would meet or exceed that contract or policies lifetime limit on all benefits, and a request for enrollment is made not later than 31 days after a claim is denied in whole or in part due to the operation of a lifetime limit on all benefits.

Qualifying Life Events After initial eligibility, applications may also be submitted within 31 days of certain qualifying life events. Ineligibility caused by fraud or misrepresentation does not qualify. Qualifying life events include:

- Marriage;
- Divorce or legal separation;
- Death of a spouse, or Dependent child;
- Birth, adoption, or placement for adoption;
- Termination or commencement of spouse's employment;
- Change in employment of the employee or spouse, from full-time to part-time status or part-time to full-time status;
- The taking of an unpaid leave of absence by the Subscriber or his/her spouse;
- Termination of the Group Contract;
- A court order requires that coverage be provided for the Subscriber's spouse or the minor child of the Subscriber or the Subscriber's spouse;
- A court order is issued changing custody of a child. The effective date of coverage is the date of the court order;
- You have exhausted your Consolidated Omnibus Budget Reconciliation Act (COBRA) Benefits;
- A Dependent satisfying or ceasing to satisfy the requirements for unmarried Dependents;
- Loss of Medicaid.

The Contract Holder can tell you when enrollment for added family members is allowed under this Group Contract.

Special Enrollment If you decline coverage for yourself or your Dependents (including your spouse) because you and your Dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your Dependents, provided you meet each of the applicable conditions outlined below, and you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption.

Conditions required for enrollment:

1. The employee has declined enrollment in writing stating that coverage under other health insurance coverage was the reason for declining coverage;
2. When the employee declined enrollment in employee and/or Dependent coverage, the employee and/or Dependent had COBRA continuation coverage under other health insurance and COBRA continuation coverage under that other insurer has since been exhausted; or
3. If the other coverage that applied to the employee and/or Dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
   a. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing;
   b. employer contributions towards the other coverage have been terminated; or
   c. loss of coverage under the Cub Care program.
   d. the member no longer resides in such coverage's permitted service area provided that no other coverage under the plan is available to the Member;
   e. benefits are no longer offered to a class of similarly situated individuals. For example, if a Plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility for coverage, even if the Plan continues to provide coverage to other employees;
   f. the application of the lifetime maximum benefit through another carrier's coverage;
   g. a dependent loses eligible dependent status. An employee who is already enrolled in a benefit option may enroll in another option under the Plan due to a dependent losing eligible dependent status; or
   h. a dependent who has other coverage loses eligibility under that coverage.

You are not required to elect and exhaust COBRA coverage under another plan to enroll in this Plan during a special enrollment period. If you do elect COBRA coverage under another plan, however, you must exhaust your COBRA coverage under that plan before you can elect to participate in this Plan. Special enrollment rights do not apply if you lose other coverage because you failed to pay your COBRA premiums.

Under the Children's Health Insurance Program Reauthorization Act of 2009, effective April 1, 2009, two new special enrollment opportunities to elect coverage have been created under your group health plan. These are in addition to the special enrollment opportunities already described in your benefit plan documents:

A special enrollment period of 60 days will be allowed under two additional circumstances:

- If your or your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program (SCHIP) is terminated as a result of loss of eligibility; or
- If you or your eligible dependent become eligible for premium assistance under a state Medicaid or SCHIP plan.

Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/SCHIP coverage or of the determination of eligibility for premium assistance under Medicaid/SCHIP.

Return From Military Service

If you return from full-time active service following a call to active military duty, no waiting period applies. You and eligible family Members can reenroll in the Plan, provided you apply for reemployment within the timeframe permitted under the Uniformed Services Employment and Reemployment Rights Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 31 days of your reemployment date. Coverage is effective on the effective date of your reemployment.

Termination of Coverage

The Subscriber, the Contract Holder, or we can cause your coverage to end. If your coverage ends for any reason except misrepresentation, fraud or nonpayment, it will end on the first day following the Grace Period (see "Paying Subscription Charges" earlier in this section for additional information). If termination of coverage is requested before the completion of the period for which we have accepted payment, payment may not be refunded, and coverage may continue until the end of that period. We reserve the right to take necessary action to collect premiums for the Grace Period.

Cancellation of the Group Contract

Notice of Cancellation If Group coverage is canceled as a result of the responsible individual's cognitive impairment or functional incapacity, the Group or subgroup may be eligible for reinstatement. The responsible individual is the person who is responsible for making premium payments on behalf of a Group or subgroup.

The right to reinstate Group coverage has the same limitations and requirements as listed in the "Notice of Cancellation" and "Right to Reinstatement" provisions as described in the "Cancellation of the Member's Contract" subsection.

This does not limit our right to cancel Group or subgroup coverage on the grounds that the employer is no longer in business, even if the end of the business results from the employer's cognitive impairment or functional incapacity.

By Notice Your Group may cancel this Contract by giving us prior written notice. It is the responsibility of your Group to notify the Subscriber of change in insurance carriers. All rights to Benefits under this Contract end on the date of cancellation.

For Non-Payment If the Group fails to pay the Subscription Charge, we may cancel the Contract. If the Group Contract is canceled for non-payment, we will notify the Subscriber of the cancellation prior to the termination date of the Contract. We will not notify the Subscriber of cancellation if the Group provides notice to us that coverage has been replaced. Your coverage will continue in force for a Grace Period of 31 days from the date Group payment is due for the Subscription Charge.

Non-Renewal Your Group may cancel the Contract by not renewing the Group Contract with us. We may cancel the Contract by not renewing the Group Contract if membership in your Group falls below the minimum number of Subscribers we require.

Other Cancellation Events We may cancel the Group's Contract if the Group gives us fraudulent information, if the Group does not meet our participation or contribution requirements, or if the Group moves outside of the geographic area we serve.

Cancellation of the Member's Contract

Ending Employment or Eligibility If the Subscriber ends employment or membership, or if you cease to meet the definition of eligible, as described in this section, your coverage will be canceled. We reserve the right to verify your initial and continued eligibility.

Deletion from Membership If you have been deleted from membership, your coverage will be canceled. The Subscriber must delete a Member from coverage if the Member is no longer eligible for reasons such as the Subscriber's divorce or legal separation, or a Member's death. The Subscriber must notify us of these events and complete a form to remove a Member. If you do not promptly disenroll your Dependents when they are no longer eligible, you will be fully responsible for all claims they incurred and for which Benefits have been paid after they were no longer eligible.

Covered Children Your coverage will be canceled if you are a covered child and:

- You reach age 26 Coverage will continue until the end of the month in which you reach age 26. Coverage will continue if you are an eligible disabled Dependent, as defined in the subsection ”Who is an Eligible Group Member?”. We reserve the right to request verification of continued eligibility.
- You cease to meet the definition of an eligible Dependent.

Non-Payment of Charges Your Contract will be canceled for your Group’s non-payment of Subscription Charges.

Misrepresentation or Fraud If you make any intentional misrepresentation, intentional omission, or use fraudulent means to obtain or continue coverage, your Contract may be rescinded. A rescission may void coverage retroactively. Any claims incurred after the date of rescission for which we are unable to recover payment from the Provider will be the responsibility of the Subscriber.

Notice of Cancellation If your coverage is canceled for non-payment of Subscription Charges or other lapse or default, we will send you a notice of cancellation. We will offer you the opportunity to reinstate your coverage as set forth below. The charges will be the same amount they would have been if the Contract had remained in force. Please refer to the Group Continuation Coverage section, below, for information regarding cancellation of COBRA coverage.

You have the right to designate another person to receive notice of cancellation of this Contract for non-payment of charges or other lapse or default. We will send the notice to you and the person you designate at the last addresses you provided to us. You also have the right to change the person you designate if you wish. In order to designate a person to receive this notice or to change a designation, you must fill out a Third Party Notice Request Form. You can obtain this form from your Group or by contacting us.

Right to Reinstatement Within 90 days after cancellation due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under a health insurance policy or certificate may request reinstatement on the basis that the loss of coverage was a result of the policyholder's cognitive impairment or functional incapacity

If you request reinstatement, we may require a Physician examination at your own expense or request medical records that confirm you suffered from cognitive impairment or functional incapacity at the time of cancellation. If we accept the proof, we will reinstate your coverage without a break in coverage. We will reinstate the same coverage you had before cancellation or the coverage you would have been entitled to if the Contract had not been canceled, subject to the same terms, conditions, exclusions, and limitations. Before we can reinstate your Contract, you must pay the amount due from the date of cancellation through the month in which we bill you. The charges will be the same amount they would have been if the Contract had remained in force.

If we deny your request for reinstatement, we will send you a Notice of Denial. You have the right to an Appeal, or to request a hearing before the Superintendent of Insurance within 30 days after the date you receive the Notice of Denial from us.

Continuation of Coverage

If your Group health coverage ends, you may be eligible for Group continuation coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA).

Group Continuation Coverage

Federal law requires that some employers sponsoring Group health plans offer employees and their families a temporary extension of health coverage at the rate of your Group Subscription Charge plus an administrative fee, when that coverage would otherwise end because of the occurrence of certain qualifying events. You are responsible for payment of the Subscription Charge at your Group rate plus the administration fee.

Qualifying events include:

- Death of the employee;
- Termination of the employee's employment or reduction in hours of employment (other than for gross misconduct);
- Divorce or legal separation from the employee;
- A Dependent child ceasing to be a Dependent;
- A retiree's coverage ceasing because of the employer's bankruptcy; and
- A covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act.

Notification - Under the law the employee or a family member (a qualified beneficiary) has the responsibility to inform the employer within 60 days of a:

- Divorce;
- Legal separation; and/or
- Child losing Dependent status under the Group health plan.

In any event, your continued Group coverage under this Contract (COBRA), will end if any of the following events occur:

- Your employer no longer provides our health insurance to any of its employees;
- We do not receive your Subscription Charge payment. In such case, your COBRA coverage will be retroactively terminated to the first day of the period for which the Subscription Charges have not been timely paid;
- You become a covered employee under any other Group health plan after the date you elect COBRA continuation coverage;
- You remarry and become covered under a Group health plan after the date you elect COBRA continuation coverage;
- You become entitled to benefits under Medicare after the date you elect COBRA continuation coverage; or
- Your COBRA entitlement period ends.

Premiums and the End of COBRA Coverage

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

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Continuation of Coverage Due To Military Service

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

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

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate and upon payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

- The 18-month period (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) may be reinstated under this Certificate.

Section Two
Utilization Management

All services you receive are subject to the provisions in this section. Failure to comply with any or all of the requirements listed below will result in a penalty, or in denial or reduction of your Benefits. If you have any questions, please call the number on the back of your Identification Card.

If you have a health concern, please contact your Physician.

The purpose of Utilization Management is to review your medical care while you are in the Hospital to determine if you are receiving medically necessary Hospital services. The program includes an ongoing monitoring of your health care needs and possible assignment of a care manager to work with you and your Physician to optimize your Benefits.

This review is to determine financial reimbursement if the requested benefit is a Covered Service. The decision for treatment is solely between the patient and Physician, regardless of the decision made regarding reimbursement.

None of our employees or the Providers we contract with to make medical management decisions are paid or provided incentives to deny or withhold Benefits for services that are medically necessary and are otherwise covered under the Contract. In addition, we require members of our clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying Benefits for services that are medically necessary and are otherwise covered under the Contract.

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

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

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

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

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

Medical Policy and Technology Assessment

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

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered. However, the Certificate of Coverage and the Group Agreement take precedence over medical policy. Medical technology is constantly changing and we reserve the right to review and update medical policy periodically.

Prior Authorization

Some services require prior authorization before Benefits will be provided. If you have any questions regarding Utilization Management or to determine which services require prior authorization, please call the number on the back of your Identification Card. Prior Authorization does NOT guarantee coverage for or payment of, the service or procedure reviewed. Contact your Physician or Anthem BCBS to be sure that prior authorization has been obtained.

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

Who is responsible for prior authorization:

- Services provided by a Network Provider: The Provider is responsible for prior authorization
- Services provided by a BlueCard or Non-Network Provider: The Member is responsible for prior authorization.

  The member is financially responsible for services and/or settings that are not covered under the Certificate based on an adverse determination of Medically Necessary Health Care or Experimental or Investigational services.

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

Procedure for Appeal of Medical Necessity

If you disagree with our determination of medical necessity, you have the right to Appeal as outlined in the "Benefit Determinations, Payments and Appeals" section of this Certificate.

Inpatient Admission Review

Pre-Admission Review All Inpatient admissions, with the exception of emergency and maternity admissions, require pre-admission review.

You, your Physician or the Provider must call the telephone number on your ID card for review before you are admitted. It is your responsibility to make sure the call has been placed. If you do not receive pre-admission review before you are admitted for non-Emergency Services, Benefits will be reduced by up to $300 for the admission. This penalty amount does not count toward your Deductible or Coinsurance limit. A penalty will not be applied to you for medically necessary inpatient facility services from a Network or BlueCard provider.

We will notify you and your Physician of the results of the pre-admission review within 2 working days of our obtaining all necessary information regarding the proposed admission. For special rules that apply to maternity admissions, see the "Continued Inpatient Stay Review" provision in this section.

Post-Admission Review All Inpatient admissions for emergency and maternity services are subject to post-admission review. For post-admission review of an emergency admission, you, a family member, your Physician, or the Provider should call within 48 hours after you are admitted. For maternity post-admission review, you, a family member, your Physician, or the Provider should call if the Hospital stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section. We will notify you and your Physician of the results of the post-admission review within 2 working days of receiving all necessary information.

If you are admitted to a Non-Network Hospital or other Non-Network health care facility, Benefits are provided at the higher benefit level only until we determine that your condition reasonably permits your transfer to a Network Hospital or other Network health care facility. If you choose not to be moved once your condition permits, Benefits will be provided at the lower benefit level from that point forward.

For emergency and maternity admissions, call the telephone number on your ID card. You can call 24 hours a day, seven days a week. During non-business hours, you may be asked to leave your information on a confidential voice messaging system.

For special rules that apply to maternity admissions, see the "Continued Inpatient Stay Review" provision in this section.

Continued Inpatient Stay Review During your stay in the Hospital, our registered nurses and Physician advisors evaluate your progress to determine the appropriateness of the services being rendered, appropriateness of the setting, discharge planning needs and coordination of alternatives to Inpatient care. If we determine that Inpatient Benefits are no longer approved, your attending Physician will be notified immediately by telephone and you will be notified by letter that Benefits will not be available beyond a certain date specified in the letter, if you are liable for the entire cost of continued care.

If you elect to continue your Hospital stay after you have been notified by letter that no further Inpatient days are approved, Benefits for Inpatient days beyond the date specified in the notification letter will be denied. You are entitled to Appeal this determination as outlined in this booklet.

Note:

Maternity Admissions - This Contract generally may not, under federal law, restrict Benefits for a mother or newborn child for any Hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

The Inpatient length of stay for a maternity admission will be determined by the attending Physician in consultation with the patient as outlined in the "Covered Services" section. In any case, this Contract may

not, under federal law, require authorization from us for prescribing a length of stay that does not exceed 48 hours (or 96 hours as applicable).

Notice Regarding Women's Health and Cancer Rights Act
Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

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

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, you may call the telephone number on your ID card.

Discharge Planning You may be ready to be discharged from a Provider even though you still need medical care. In that case, we will work with you and your Physician to make arrangements for treatment even after you are released from the Provider.

Inpatient Mental Health/Substance Abuse Review Authorization for Inpatient Mental Health and Substance Abuse services must be obtained through the behavioral health care manager. You, your doctor, or the Provider must call for authorization. Unless you have an Emergency Medical Condition, you must call the telephone number on your ID card for prior authorization of all Inpatient Mental Health and Substance Abuse services before you receive the services. It is your responsibility to make sure you receive prior authorization for all non-emergency Inpatient Mental Health and Substance Abuse services. If you do not call for prior authorization for Inpatient Mental Health and Substance Abuse services before you receive the services, your Benefits may be reduced by up to $300. Benefits may be denied if it is determined that services received were not medically necessary. A penalty will not be applied to you for medically necessary inpatient facility services from a Network or BlueCard provider.

Health Plan Individual Case Management

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

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

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

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

Continuity of Care

If you are undergoing a course of treatment and the treating Provider withdraws from this network, we will notify you of the termination. You may be allowed to continue receiving care from the withdrawing Provider for a period of 60 days from the date of notice of termination or through the end of postpartum care if you are in the second trimester of a pregnancy, if the Provider:

- Agrees to accept the same rates of reimbursement that were in effect prior to the date of termination;
- Agrees to adhere to our applicable quality assurance standards and to provide us with the necessary medical information related to the care provided you; and
- Agrees to adhere to our policies and procedures.

Network Provider Unavailable

If you are unable to obtain services from a Network Provider, you or your doctor should call the telephone number on your ID card. Our care managers will work with you or your doctor to locate a Network Provider. If it is determined by the care manager that no Network Provider is available, we will authorize Covered Services from a Non-Network Provider. Benefits will be reimbursed at the higher network level.

How to Access Primary and Specialty Care Services

Your health plan covers certain primary and specialty care services. To access primary care services, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your health plan covers care provided by any network specialty care provider you choose. Referrals are never needed to visit any network specialty care provider.

To make an appointment call your physician's office:

- Tell them you are an Anthem PPO member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, take your Member ID card.

When you need care after normal office hours

After hours care is provided by your physician who may have a variety of ways of addressing your needs. Call your physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an emergency, call 911 or go to the nearest emergency room.

Voluntary Clinical Quality Programs

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

Voluntary Wellness Incentive Program

We may offer health or fitness programs for purchase by your Group. These programs are separate and not part of your Group Health Plan, and are not guaranteed under your *insurance* Certificate and could be removed at any time. If your Group has chosen one of these options, You may receive incentives such as gift cards by being part of or completing such voluntary wellness programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by reaching specified goals based on health factors when done in accordance with state or federal law. However, if it is too difficult due to a medical condition for you to meet the standards for a reward under such a program, or if it is medically unwise for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Section Three
Covered Services

This section, along with the "Exclusions" section, explains health care services for which we will and will not provide Benefits. All Benefits and Covered Services are subject to the Deductibles, Coinsurance, Copayments, maximums, exclusions, limitations, terms, provisions and conditions of this Contract, including any attachments and Amendments or riders. Benefits for Covered Services are based on the maximum allowable amount. To receive maximum Benefits for Covered Services, you must follow the terms of the Certificate, including, use of Network Providers and obtaining any required prior authorization.

Our payment for Covered Services will be limited by any applicable Copayment, Deductible, or annual or lifetime maximum. Please check your Schedule of Benefits for Deductibles, Copayments, Coinsurance, maximums, and limitations that apply. Please see the "Utilization Management" section for conditions that apply to all Inpatient admissions.

Benefits for Covered Services may be payable subject to an approved treatment plan. Only medically necessary care is covered. Although we do not provide Benefits for Covered Services that do not meet our definition of medical necessity, you and your Physician must decide what care is appropriate. The fact that a Physician 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. If you choose to receive care that is not a Covered Service or does not meet our definition of medical necessity, we will not provide Benefits for it. Anthem BCBS bases its decisions about referrals, prior authorization, medical necessity, Experimental services and new technology on medical policy developed by Anthem BCBS. Anthem BCBS 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.

Unless specifically stated otherwise, all Benefits, limitations and exclusions under this Contract apply separately to each covered family member.

A Member's right to Benefits for Covered Services provided under this Certificate is subject to certain policies or guidelines and limitations, including, but not limited to, Anthem BCBS Medical Policy, Continued Inpatient Stay Review, Pre-admission Review, Post-Admission Review, and Prior Authorization. A description of each of these guidelines explaining its purpose, requirements and effects on Benefits is provided in the "Utilization Management" section. Failure to follow the Utilization Management guidelines for obtaining Covered Services will result in reduction or denial of Benefits.

Allergy Testing and Injections We provide Benefits for allergy testing and injections.

Ambulance Services

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

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

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and an approved Facility.

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

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

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

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

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

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

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

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

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

We provide Benefits for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. This service is covered only when used locally to or from a Hospital when other transportation would endanger your health.

If no Hospital in your local area is equipped to provide the care you need, we will provide Benefits for ambulance transportation to the nearest facility outside your area that can provide the necessary care. If you are transported to a Hospital that is not the nearest Hospital that can meet your needs, Benefits will be based on transport to the nearest Hospital that can meet your needs.

Ambulatory Surgery Centers We provide Benefits for certain Covered Services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility's licensure.

Anesthesia Services We provide Benefits for anesthesia only if administered while a Covered Service is being provided, except as outlined in the 'Dental Procedures' provision. We do not provide Benefits for local or topical anesthesia unless it is part of a regional nerve block.

Autism Spectrum Disorders We provide coverage for members who are five years of age or under for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders is covered when it is determined by a licensed physician or licensed psychologist that the treatment is Medically Necessary Health Care, as defined in the Certificate of Coverage. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.

Please refer to your Schedule of Benefits for limits that may apply.

Blood Transfusions We provide Benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

Chemotherapy Services We provide Benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by us for medically accepted indications or as required by law.

Chiropractic Care We provide Benefits for chiropractic care. See the 'Manipulative Therapy' provision for additional information. Please see your Schedule of Benefits for limits that apply.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
   i. The Department of Veterans Affairs.
   ii. The Department of Defense.
   iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

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

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

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

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

Contraceptives We provide Benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis.

Dental Procedures We will provide Benefits for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the Member is classified as vulnerable. Examples of vulnerable Members include, but are not limited to the following:

- Infants
- Individuals exhibiting physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result
- Individuals with acute infection
- Individuals with allergies
- Individuals who have sustained extensive oral-facial, or dental trauma
- Individuals who are extremely uncooperative, fearful, or anxious

Dental Services We provide Benefits only for the following:

- Setting a jaw fracture
- Removing a tumor (but not a root cyst)

- Removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting
- Treatment within six months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later
- Repairing or replacing dental Prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later.

Services for accidental injuries relating to biting and chewing are not covered.

Diabetic Services We provide Benefits for diabetes medication, equipment, and supplies which are medically appropriate and necessary. Benefits are limited to: insulin, insulin pumps, oral hypoglycemic agents, glucose monitors, test strips, syringes, lancets, and Outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by us.

Diagnostic Services We provide Benefits for Diagnostic Services, including diagnostic laboratory tests and x-rays, when they are ordered by a Provider to diagnose specific signs or symptoms of an illness or injury or when the services are part of well-baby or well-adult care stated as covered under this contract.

You must receive prior authorization from us for the diagnostic services which include but are not limited to: CT Scans, MRI/MRAs, Nuclear Cardiology, and PET Scans.

Please call the number on the back of your Identification Card if you have questions regarding which services require prior authorization.

Durable Medical Equipment and Prostheses If more than one treatment, prosthetic device, or piece of Durable Medical Equipment may be provided for your disease or injury, Benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs. These terms apply to the following services:

Durable Medical Equipment We provide Benefits for the rental or purchase of Durable Medical Equipment. Whether you rent or buy the equipment, we provide Benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, we will make monthly payments only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first.

Benefits for replacement or repair of purchased Durable Medical Equipment are subject to our approval. We do not provide Benefits for the repair or replacement of rented equipment.

Supplies are covered if they are necessary for the proper functioning of the Durable Medical Equipment.

Prostheses We provide Benefits for Prostheses. Prostheses include artificial limbs and prosthetic appliances. Please refer to the "Exclusions" section for additional information.

Early Intervention Services We provide benefits for early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay. A referral from the child's primary care provider is required.

Please refer to your Schedule of Benefits for limits that may apply.

Emergency Room Care We provide Benefits for emergency room treatment received for medical emergencies once you pay the emergency room Copayment listed on your Schedule of Benefits. You or a designated person should contact your Physician within 48 hours from the time you receive care.

If you are admitted to the Hospital from the emergency room, the emergency room Copayment is waived. You or a designated person should contact your Physician within 48 hours from the time you are admitted. If you do not contact your Physician, you or someone you designate should call the telephone number listed on your ID card within 48 hours of admission.

Family Planning We provide Benefits for family planning. See the 'Contraceptives' provision within this section for details.

Foot Care We provide Benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

Freestanding Imaging Centers We provide Benefits for Diagnostic Services performed by Freestanding Imaging Centers. All services must be ordered by a Provider.

Hearing Care We provide benefits for wearable hearing aids for covered Members up to age 18. Coverage is limited to one hearing aid for each hearing-impaired ear every 36 months. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

Home Health Care Services We provide Benefits for home health care services when services are performed and billed by a home health care agency. A home health care agency must submit a written plan of care, and then provide the services as approved by us.

We provide Benefits for the following home health care services:

- Physician home and office visits;
- Registered nurse (RN) or licensed practical nurse (LPN) nursing visits;
- Services of home health aides when supervised by an RN;
- Paramedical services, including physical therapy, speech therapy, occupational therapy, inhalation therapy, and nutritional guidance;
- Supportive services, including Prescription Drugs, medical and surgical supplies, and oxygen.

Hospice Care Services We provide Benefits for Hospice Care services furnished in your home by a Home Health Agency to a Member who is terminally ill and the Member's family. A Member who is terminally ill means a person who has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course.

We provide Benefits for Hospice Care services by a Home Health Agency up to 24 hours during each day of care. Hospice Care services are provided according to a written care delivery plan developed by a Hospice Care Provider and the recipient of Hospice Care services. Prior approval is required when care exceeds eight hours a day. In this case, the agency must submit a plan of care to receive approval. The agency must then submit a plan of care every 14 days to maintain approval. To be eligible for Hospice Care services, the patient need not be homebound or require skilled nursing services. Coverage for Hospice Care services is provided in either a home or Inpatient setting.

Hospice Care services include, but are not limited to: Physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and Durable Medical Equipment, occupational, physical or speech therapies, home health care services, bereavement services, and volunteer services.

Hospice Respite Care We provide Benefits for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member or other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide Hospice Care.

Before the patient receives respite care at home, a Home Health Agency must submit a plan of care for approval. Prior approval is also required when respite care is provided by an Inpatient Hospice.

Inpatient Hospice Services We provide Benefits for Inpatient Hospice Care at an acute care Hospital or Skilled Nursing Facility. The same services are covered for Inpatient Hospice Care as are covered under the 'Inpatient Hospital Services' provision.

Inborn Errors of Metabolism We provide Benefits for metabolic formula and special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by Inborn Error(s) of Metabolism. This benefit is limited to those Members with diseases caused by Inborn Error(s) of Metabolism.

Independent Laboratories We provide Benefits for Diagnostic Services performed by independent laboratories. All services must be ordered by a Provider.

Infant Formula We provide Benefits for amino acid-based elemental infant formula for children 2 years of age and under when a covered Provider has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. A covered Provider may be required to confirm and document ongoing medical necessity at least annually.

Benefits for amino acid-based elemental infant formula will be provided without regard to the method of delivery of the formula.

Benefits are provided when a covered Provider has diagnosed and through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;
- Laboratory – or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis;
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
- Cystic fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula.

Infusion Therapy We provide Benefits for infusion therapy when services are provided by a licensed Provider, facility, ambulatory infusion center, or home infusion therapy provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered.

Inhalation Therapy We provide Benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

Inpatient Hospital Services We provide Benefits for the following Inpatient Hospital services:

- Room and board, including general nursing care, special duty nursing, and special diets, in a semiprivate room or a private room when medically necessary or when the facility offers only private rooms;
- Use of intensive care or coronary care unit;
- Diagnostic Services;
- Medical, surgical, and central supplies;
- Treatment services;
- Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy, and radiotherapy services;
- Phase I Cardiac Rehabilitation;
- Medication used when you are an Inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by us for medically accepted indications or as required by law;
- Blood and blood derivatives;
- Prostheses or Orthotic Devices;
- Newborn care, including routine well-baby care.

Benefits for an Inpatient Stay in a Hospital will end with the earliest of the following events:
- You are discharged as an Inpatient;.
- You reach any of the limits or maximums shown in your Schedule of Benefits;
- Your Physician, Hospital personnel, or we notify you that Inpatient care no longer meets our guidelines for continued Hospital admission.

Manipulative Therapy We provide Benefits for treating acute musculo-skeletal disorders. No Benefits are provided for ancillary treatment such as massage therapy, heat, and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for Maintenance Therapy for chronic conditions. Please see your Schedule of Benefits for limits that apply.

Massage Therapy We provide Benefits for massage therapy when services are part of an active course of treatment and the services are performed by a Covered Provider (Please see definition of Covered Provider.). A massage therapist is not a Covered Provider.

Medical Care We provide Benefits for medical care and services including office visits and consultations, Hospital and Skilled Nursing Facility visits, and pediatric services.

Medical Supplies We provide Benefits for medical supplies furnished by a Provider in the course of delivering medically necessary services. This benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are medically necessary for injecting insulin or a drug prescribed by a Physician.

Mental Health and Substance Abuse Services We provide Benefits for only the following Mental Health and Substance Abuse services when they are for the active treatment of Mental Health and Substance Abuse disorders. These services must be part of an established plan of treatment and must be performed and independently billed by a Provider acting within the scope of his or her license.

Benefits for Inpatient, Outpatient, and day treatment services for Mental Health and Substance Abuse are provided when you receive them from a Provider. You will receive maximum Benefits for Mental Health and/or Substance Abuse Services when you receive care from Network Providers.

Covered Services include the following:

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

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or

Any agency licensed by the state to give these services, when we have to cover them by law.

If you receive Provider services from a Community Mental Health Center or Substance Abuse Treatment Facility, services must be:

- Supervised by a licensed Physician, licensed clinical psychologist, licensed clinical professional counselor, or licensed clinical social worker; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

You will receive maximum Benefits for Mental Health and/or Substance Abuse services when you receive care from Network Providers.

- Individual and group counseling;
- Family counseling;
- Psychological testing;
- Diagnostic and evaluation services;
- Emergency treatment for the sudden onset of a Mental Health or Substance Abuse condition requiring an immediate and acute need for treatment;
- Intervention and assessment;
- Room and board, including general nursing;
- Prescription Drugs, biologicals, and solutions administered to Inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic and evaluation services;
- Intervention and assessment;
- Facility-based professional and ancillary services;
- Individual, Group and family counseling;
- Psychological testing;
- Emergency treatment for the sudden onset of a Mental Health or Substance Abuse condition requiring immediate and acute treatment.

The “Utilization Management” section contains additional information about seeking Mental Health and Substance Abuse services. Please refer to your Schedule of Benefits for additional information regarding Mental Health and Substance Abuse Benefits.

Morbid Obesity We provide limited Benefits for treatment of Morbid Obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. Benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty. Prior authorization is required. We do not provide Benefits for weight loss medications.

Nutritional Counseling We provide Benefits for nutritional counseling when required for a diagnosed medical condition.

Obstetrical Services and Newborn Care We provide Benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. We do not provide Benefits for routine circumcisions.

Office Visits We provide Benefits for office visits. Office visits are subject to a Copayment. Please refer to your Schedule of Benefits. Office visits to Network Providers are not subject to the Deductible or Coinsurance. Office visits to Non-Network Providers are not subject to the Deductible and will be paid at the non-network level of Benefits. Office visits include visits to a Walk-In Center. Office visits include visits to a retail health clinic. Services at a retail health clinic are limited to basic health care services to Members on a 'walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by physician's assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Online Visits When available in your area, your coverage will include online visit services. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Covered Services include a medical consultation using the internet via a webcam, chat or voice.

Non Covered Services include, but are not limited to, communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit precertification
- Physician to Physician consultation

Please refer to the "Telemedicine" provisions as you may have additional or different services available.

Organ and Tissue Transplants We provide Benefits for organ and tissue transplant procedures listed below. You must receive prior approval from us before you are admitted for any transplant procedure. Your Physician will work with our registered nurses and Physician advisors to evaluate your condition and determine the medical appropriateness of a transplant procedure. Failure to receive approval prior to admission may result in a denial or reduction of Benefits.

Transplants include:
heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.

No other organ or tissue transplant is covered. We will not pay any Benefits for any services related to a transplant we do not cover.

We provide Benefits as follows:

- If both the donor and the recipient are covered Members of ours, we will provide Benefits to cover both patients for organ and tissue transplants;
- If the recipient is a Member under a Contract with us but the donor is not, we will provide Benefits for both the recipient and donor as long as similar Benefits are not available to the donor from other sources;
- If the recipient is not a Member under a Contract with us but the donor is a Member, we will not provide Benefits to either the donor or the recipient.

Coverage for the cost of testing for bone marrow donation suitability

The Plan provides coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:

A. The covered member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;

B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;

C. At the time of the testing, the covered member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.

This benefit is limited to one test per lifetime.

Orthotic Devices We provide Benefits for certain Orthotic Devices, such as orthopedic braces, back or surgical corsets, and splints. We do not provide Benefits for the following whether available over the counter or by prescription: arch supports, shoe inserts, other foot support devices, orthopedic shoes (unless attached to a brace), support hose, and garter belts.

Outpatient Services We provide Benefits for the following Hospital Outpatient and Rural Health Center services:

- Emergency room services/emergency care;
- Removal of sutures;
- Application or removal of a cast;
- Diagnostic Services;
- Surgical Services;
- Removal of impacted or unerupted teeth;
- Endoscopic procedures;
- Blood administration;
- Radiation Therapy;
- Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. Benefits for these services have special requirements. Please check with us to see if you are eligible for Benefits;
- Outpatient educational programs such as diabetes education. Please check with us to see if you are eligible for benefits.

Parenteral and Enteral Therapy We provide Benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

Physical and Occupational Therapy We provide Benefits for short-term physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement. Benefits are subject to a combined Calendar Year limit as described on your Schedule of Benefits. Services are covered only when provided by a licensed Provider acting within the scope of his/her license.

No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

Prescription Drugs We provide benefits under your prescription drug card program for FDA approved prescription drugs and medicines bought for use outside a hospital. The Covered Drug Copayment or Coinsurance may vary based on whether the Prescription Drug has been classified by Anthem as a Tier 1, Tier 2, or Tier 3 Drug.

Anthem BCBS/WellPoint, Inc. has established the WellPoint National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignment of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determination of tiers is made by Anthem BCBS/WellPoint based upon clinical decisions provided by the National P & T Committee, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives, and where appropriate, certain clinical economic factors.

You may review a copy of the current tier listing online at: wellpointnextrx.com or you may request a copy of the tier listing by calling a customer service representative at the number of the back of your ID card. The tier listing is subject to periodic review and amendment. Inclusion of a drug or related item on the tier listing is not a guarantee of coverage. Refer to the prescription drug Benefit sections in this Certificate for information on coverage, limitations and exclusions**.**

We retain the right at Anthem BCBS/WellPoint's discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another Tier.

- Tier 1 drugs have the lowest copayment. This tier will contain low cost and preferred medications that may be generic, single source brand drugs, or multi-source brand drugs.
- Tier 2 drugs will have a higher copayment than those in tier 1. This tier will contain preferred medications that may be generic, single source, or multi-source brand drugs.
- Tier 3 drugs will have a higher copayment than those in tier 2. This tier will contain non-preferred and high cost medications. This will include medications considered generic, single source brands, or multi-source brands.

From time to time we may initiate various programs to encourage covered persons to utilize more cost effective or clinically-effective drugs including, but not limited to, generic drugs, mail order drugs, OTC, or

preferred products. Such programs may involve reducing or waiving copayments or coinsurance for certain drugs or preferred products for a limited period of time.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require prior authorization of benefits. 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 pharmacy benefits manager (PBM). The PBM is a pharmacy benefit management company with which we contract to manage your pharmacy benefits. Please see the "Benefit Determinations, Payments and Appeals" section for additional information.

Certain Prescription Drugs are not covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem on appeal to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing for the appeal, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative. For additional information please consult our website at www.wellpointnextrx.com or contact Customer Service at the number on the back of your ID card.

The PBM uses pre-approved criteria, developed by Anthem's national Pharmacy and Therapeutics Committee and reviewed and adopted by Anthem. The PBM communicates the results of the decision to the pharmacist. The PBM may contact your prescribing physician if additional information is required to determine whether prior authorization should be granted. If prior authorization is denied, you have the right to appeal through the appeals process outlined in the "Benefit Determinations, Payments and Appeals" section of this certificate.

Please note one exception to the prior authorization requirement. When the prior authorization is initiated but cannot be completed, Anthem may authorize coverage for a sufficient amount of the Prescription Drug which will provide the additional time for Anthem to make the prior authorization decision.

For a list of current drugs requiring prior authorization, please contact a customer service representative at the number on the back of your ID card or consult the website at **www.wellpointnxtrx.com.** The tier listing is subject to periodic review and amendment. Inclusion of a drug or related item on the tier listing is not a guarantee of coverage.

Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products are covered. Benefits include FDA approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. Some quantity limitations may apply. These services will be covered under the "Preventive Care" benefit. Please see that section for further details.

Continuity of Prescription Drugs
We reserve the right to request a review of your previous insurance carrier's prescription drug prior authorization with your prescribing provider. If your provider participates in the review and requests that the prior authorization be continued, we will honor the previous insurance carrier's prior authorization for a period not to exceed 6 months beginning with your effective date of coverage with us.

Prescription Drugs From A Retail Pharmacy When your prescription is filled at a retail Pharmacy, you pay the amount shown on your Schedule of Benefits. Certain participating retail pharmacies can fill your prescription at the same Copayments that apply to the mail order Pharmacy. Please ask your Pharmacy if they participate in this special arrangement or call our Customer Service Department at the number on your ID card for a list of participating pharmacies.

Prescription Drugs By Mail Your Contract may allow you to obtain Prescription Drugs by mail. To obtain Benefits for Prescription Drugs by mail, complete a mail order Pharmacy form, available through our Customer Services Department, and mail it with your prescription. You must pay the applicable Copayment amount indicated on your Schedule of Benefits.

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

Specialty pharmacies may fill retail and mail service Specialty Drug prescription orders, subject to a 30-90 day supply. The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, including a Network Specialty Pharmacy, a Non-Network Pharmacy, or a mail order vendor. You may obtain a list of specialty drugs available through the Specialty Pharmacy Network by contacting the Customer Service number on the back of your ID card, or by visiting our website www.anthem.com.

A list of participating Specialty Pharmacies is available by contacting the Customer Service number on your ID card, or by visiting our website www.anthem.com.

Changes In Your Prescription Your pharmacist may check your prescription to determine if there may be harmful interactions between the prescription you are filling and any other prescription you may be taking. The pharmacist may contact your Physician to discuss possible changes to your prescription.

Refills on Prescriptions Your Physician will indicate the number of refills for your prescription. We will cover the refill for your prescription when you have taken 85% of the medication, based on the dosage schedule prescribed by the Physician. We will not provide Benefits for refills that are filled sooner.

Maintenance Prescription Supplies Benefits are provided for up to a 90-day supply if prescribed by your Physician as medically appropriate. Please refer to your Schedule of Benefits for Copayment amounts that apply to you.

Step-Therapy Protocol Screening For many conditions, the FDA has approved more than one medication for use. These include first-line medications customarily utilized to treat the condition and second-line medications. Second-line medications may be prescribed for patients who have utilized a first-line medication for their condition which has not been completely effective or for patients that may experience side effects with the first-line medication. We will provide Benefits for certain second-line medications only after you have previously attempted to use an appropriate first-line medication and it was not completely effective or it would result in complications or side-effects. Please consult wellpointnextrx.com for a listing of medications that require prior authorization.

Therapeutic Substitution of Drugs Your Pharmacy benefit includes a therapeutic drug substitution program approved by Anthem and managed by the PBM. This voluntary program is designed to inform Members and Physicians about therapeutic alternatives. The PBM may contact the Member**,** the Member's representative, or the prescribing Physician to make the Member aware of substitution options. Only the Member and the Member's Physician can determine whether the therapeutic substitution is appropriate.

Half-Tablet Program The Half-Tablet Program will allow Members to pay a reduced copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Member to obtain a 30-day

supply (15 tablets) of the higher strength medication when written by the Physician to take "1/2 tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member's decision to participate should follow consultation with and the concurrence of his/her Physician. To obtain a list of the products available on this program call the Customer Service number on the back of your ID card.

Vacation Supplies If you are going out of the area for an extended period of time and your supply of medications is not sufficient for this period, you may contact your Pharmacy or the prescribing Physician prior to leaving the area to receive an early refill or an extended-day supply of medications while you are away from home. Controlled substances are excluded from this program.

Preventive and Well-Care Services We provide Benefits for preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. Please refer to the "Preventive Care" amendment included with this Certificate for details.

Radiation Therapy We provide Benefits for Radiation Therapy.

Reconstructive Surgeries, Procedures and Services Benefits are available for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

1. necessary due to accidental injury; or
2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
3. Medically Necessary Health Care to restore or improve a bodily function, or
4. necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate
5. for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Certificate.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to Anthem Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures and services eligible for consideration based on Anthem Medical Policy coverage criteria are:

1) Mastectomy for Gynecomastia
2) Mandibular/Maxillary orthognathic surgery
3) Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants
4) Port Wine Stain surgery

Skilled Nursing Facility Services We provide Benefits for Inpatient Skilled Nursing Facility services. We do not cover custodial confinement.

Smoking Cessation We provide Benefits for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation. To be eligible for Benefits, these products and medications must be prescribed by your Physician.

- NRT products can include but are not limited to, nicotine patches, gum, or nasal spray.

- We provide Benefits for follow-up smoking cessation education and counseling.
- We provide Benefits for completing an approved smoking cessation program.

Please see your Schedule of Benefits for applicable Copayment, Coinsurance, Deductibles, limitations, and maximums that apply.

Speech Therapy We provide Benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement. Benefits are subject to a combined Calendar Year limit as described on your Schedule of Benefits. Services are covered only when provided by a licensed Provider acting within the scope of his/her license.

No Benefits are provided for:
- Deficiencies resulting from mental retardation; or
- Dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Surgical Services Benefits are provided for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care.

For covered surgeries, services of surgical assistants are payable as a surgery benefit if included on the list of payable Anthem surgical assistant codes. If you have questions about your surgical procedure, please contact your physician or Customer Service.

Telemedicine Benefits are provided for telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a covered health care provider. Coverage for health care services provided through telemedicine will be determined in a manner consistent with coverage for health care services provided through in-person consultation.

Section Four
Exclusions

This section, along with the "Covered Services" section, explains the types of health care services we will and will not provide Benefits for. The exclusions listed below are in addition to those set forth elsewhere in this Certificate. Charges you pay for services related to non-Covered Services do not count toward any Deductible, Coinsurance, or out-of-pocket limits.

Acupuncture We do not provide benefits for acupuncture.

Alternative Medicines or Complementary Medicines We do not provide Benefits for alternative or complementary medicine. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven or established, as determined by Anthem's Medical Director. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless otherwise stated in the Covered Services section), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

Artificial Hearts We do not provide Benefits for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a heart transplant.

Asthma Education We do not provide benefits for asthma education programs.

Benefits Available from Other Sources We do not provide Benefits for any services to the extent that there is no charge to you or to the extent that you can recover expenses through a federal, state, county, or municipal law. This is the case even if you waive or fail to assert your rights under these laws. However, this exclusion does not apply to Medicaid.

Biofeedback We do not provide benefits for biofeedback.

Blood We do not provide Benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

Commercial Weight Loss Programs Weight loss programs not approved by us, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate of Coverage.

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

This exclusion does not apply to Medically Necessary treatments for morbid obesity.

Cosmetic Services We do not provide Benefits for Cosmetic Services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions. Examples of Cosmetic Services include, but are not limited to: surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Custodial Care We do not provide Benefits for services, supplies or charges for Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a Provider**.**

Dental Services We do not provide Benefits for Orthognathic Surgery, dentistry, dental surgery, dental implants or any other services unless specifically listed as covered in the "Covered Services" section.

Department of Veterans Affairs We do not provide Benefits for any treatments, services, or supplies provided to veterans by the Department of Veterans Affairs, its Hospitals, or facilities if the treatment is related to your service connected disability.

Experimental/Investigational Services We do not provide Benefits for any drugs, supplies, Providers, medical, or health care services that are Experimental or Investigational. This exclusion includes the cost of all services from a Provider including the cost of all services while you are an Inpatient receiving an Experimental or Investigational service or surgery. Drugs classified as Treatment Investigational New Drugs (IND) by the FDA and devices with the FDA Investigational Device Exemption (IDE), any device to which the FDA has limited access or otherwise limited approval, and any services involved in clinical trials are considered Experimental or Investigational.

Facilities of the Uniformed Services We do not provide Benefits for any treatments, services, or supplies provided by or through any health care facility of the uniformed services. This exclusion does not apply if you are a military dependent or retiree.

Family Planning Services We do not provide Benefits for services to reverse voluntarily induced sterility; non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices.

Food or Dietary Supplements We do not provide Benefits for nutritional and/or dietary supplements, except as provided in this Certificate of Coverage or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

Genetic Testing and Counseling We do not provide Benefits for genetic counseling, except as required by law. We do not provide Benefits for genetic testing, except in accordance with WellPoint Medical Policy. Medical technology is constantly evolving and medical policies are subject to change without notice.

Government Institutions We do not provide Benefits for any services provided to you by any institution that is owned or operated by the federal government or any state, county, or municipal government.

Health Club Memberships We do not provide Benefits for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Hearing Care We do not provide Benefits for hearing examinations except for screening Members under the age of 19 years or when related to injury or disease. Please see Hearing Care in the Covered Services section for benefits for hearing aids.

Infertility We do not provide Benefits for Diagnostic Services, procedures, treatment or other services related to Infertility. This exclusion also applies to drugs used to enhance fertility. We do not provide Benefits for costs associated with achieving pregnancy through surrogacy.

Leased Services and Facilities We do not provide Benefits for any health care services or facilities that are not regularly available in the Provider you go to, that the Provider must rent or make special arrangements to provide, and that are billed independently.

Maintenance Therapy We do not provide Benefits for maintenance services, treatments or therapy.

Major Disaster, Epidemic, or War In the event of a major disaster, epidemic, war (declared or undeclared), or other circumstances beyond our control, we will make a good faith effort to provide or arrange for Covered Services. We will not be responsible for any delay or failure to provide services due to lack of available facilities or personnel. Benefits are not provided for any disease or injury that is a result of war, declared or undeclared, or any act of war.

Massage Therapy We do not provide Benefits for massage therapy when services are not part of an active course of treatment and are not performed by a Covered Provider (Please see definition of Covered Provider.). Services by a massage therapist are not covered.

Medically Unnecessary Services We do not provide Benefits for any treatment, services, or supplies that do not meet the definition of Medically Necessary Health Care.

Medicare We may not provide Benefits in situations where Medicare would have primary liability for health care costs under federal Medicare Secondary Payor regulations. If you are enrolled in Medicare Part A and/or Part B, and Medicare is the primary payor, we may provide Benefits only for balances remaining after Medicare has made payment. If you are eligible for premium free Medicare Part A, and Medicare would be the primary payor, we may pay Benefits as if Medicare had made their primary payments for Medicare Part A and/or Part B, even if you fail to exercise your right to premium free Medicare Part A coverage.

Mental Health, Substance Abuse Treatment and Lifestyle Services We do not provide Benefits for any of the following services or any services relating to:

- Smoking clinics;
- Sensitivity training;
- Encounter Groups;
- Educational programs except as indicated in the “Covered Services” section;
- Marriage, guidance, and career counseling;
- Codependency;
- Adult Children of Alcoholics (ACOA);
- Pain control (except as required by law for Hospice Care services);
- Activities whose primary purpose is recreational and socialization.

Miscellaneous Expenses We do not provide Benefits for Provider charges to provide required information to process a claim or application for coverage. We do not provide Benefits for any additional costs associated with an Appeal of a claim decision.

Missed Appointments We do not provide Benefits for missed appointments. Providers may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No Benefits are available for these charges. You are solely responsible for these charges.

Orthognathic Surgery We do not provide Benefits for Orthognathic Surgery, except as stated in the Covered Services, Reconstructive Surgeries, Procedures and Services section.

Orthotic Devices We do not provide Benefits for Orthotic Devices unless stated as covered in the "Covered Services" section of this Contract.

Personal Comfort Items We do not provide Benefits for any personal comfort items such as television rentals, newspapers, telephones, and guest meals.

Physical and Occupational Therapy We do not provide Benefits for massage therapy, treatment such as paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

Prescription Drugs We do not provide Benefits for the following:

- Any refill in excess of the number specified by the Physician or for refills dispensed after one year from the date of original prescription order;
- Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, topical dental fluorides;
- Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form. This exclusion does not apply to over-the-counter products that the Plan must cover under federal law with a Prescription;
- Prescription Drugs for the treatment of weight reduction/anorectics;
- Medication that is taken by or administered to an Inpatient;
- Experimental or Investigational drugs or any Food and Drug Administration (FDA) Treatment Investigational New Drugs (IND), unless the intended use of the drug is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug is recognized in one of the standard reference compendia or in peer-reviewed medical literature;
- Disposable supplies such as alcohol, cotton balls, or bandages used to administer medications;
- Prescription Drugs dispensed by a Physician;
- Prescription Drugs used to enhance fertility;
- Prescription Drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law;
- Compound drugs, unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer.

Preventive Care We do not provide Benefits for preventive care and well-care services, unless otherwise stated in the "Covered Services" section.

Prostheses We do not provide Benefits for dental Prostheses, or prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes.

Refractive Eye Surgery We do not provide Benefits for refractive eye surgery, such as radial keratotomy, for conditions that can be corrected by means other than surgery.

Routine Circumcisions We do not provide Benefits for routine circumcisions.

Routine Foot Care We do not provide Benefits for any services rendered as part of routine foot care.

Services After Your Contract Ends We do not provide Benefits for services that are provided after your Contract ends unless your Group cancels coverage with Anthem BCBS and you are an Inpatient on the Group cancellation date. If you are an Inpatient on the date your Group cancels coverage with Anthem BCBS and you have care after the date your Group coverage ends and your Group has replacement coverage, the replacement carrier pays primary benefits for the Inpatient care provided after the effective date and this Plan pays secondary Benefits. If there is no replacement carrier, this Plan pays primary Benefits. Benefits under this Plan will end when you are no longer disabled, when you reach any Contract maximums, when you are discharged as an Inpatient and you are no longer disabled, or six months from the termination of your Group Contract, whichever occurs first.

Services Before the Effective Date We do not provide Benefits for any treatment, services, supplies, medical equipment, or Prostheses rendered to you or received before your individual effective date of coverage. Services you receive during an Inpatient Stay that started before you enrolled are covered only as of your effective date on this Contract. For an Inpatient Stay, care that is provided before your effective date is not covered.

Services by Ineligible Providers We do not provide Benefits for services received from an individual or entity that is not licensed by law to provide Covered Services as defined in this Certificate. Examples may include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

Services by Relatives or Volunteers We do not provide Benefits for any services provided in any capacity by immediate family members or step-family members, for example, spouse, father, mother, brother, sister, son or daughter. We do not provide Benefits for services by volunteers, except as outlined in the "Hospice Care Services" provision.

Services Not Listed As Covered We do not provide Benefits for any service, procedure, or supply not listed as a Covered Service in this Contract.

Services Related to Non-Covered Services We do not provide Benefits for services related to any non-Covered Service or to any complications and conditions resulting from any non-Covered Service.

Sex Changes We do not provide Benefits for any services related to any transsexual operation.

Shoe Inserts We do not provide Benefits for shoe inserts.

Speech Therapy We do not provide Benefits for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Sterilizations and Reverse Sterilizations We do not provide Benefits for sterilizations or services to reverse voluntarily induced sterility.

Surrogate Mother Services We do not provide Benefits for any services or supplies provided to a person not covered under the Certificate of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Temporomandibular Joint (TMJ) Syndrome Services We do not provide Benefits for surgical and non-surgical examination; diagnosis, including invasive (internal) and non-invasive (external) procedures and tests; and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-Covered Services include but are not limited to: physiotherapy, such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound, or diathermy; behavior modification such as biofeedback, psychotherapy; appliance therapy such as occlusal appliances (splints) or other oral Prosthetic Devices and their adjustments; orthodontic therapy such as braces; prosthodontic therapy such as crowns, bridgework; and occlusal adjustments.

This exclusion does not apply to services listed as covered in the "Dental Services" provision.

Travel Expenses We do not provide Benefits for any travel expenses, whether or not the travel is recommended by a Provider.

Vision Care We do not provide Benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises. We do not provide Benefits for the prescription, fitting, or purchase of glasses or contact lenses except when medically necessary to treat accommodative strabismus, cataracts, or aphakia.

Workers' Compensation We do not provide Benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide Benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide Benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs.

We will pay Benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met**:

- You are making a claim under the Workers' Compensation Act;
- Your health care coverage is provided through an employee health plan;
- Your employer or your employer's workers' compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
- The Workers' Compensation Board has not made a determination on your claim;
- Your employer has made no payment on or settlement of your claim.

Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this plan, as discussed in the "Benefit Determinations, Payments and Appeals" section.

Section Five
Benefit Determinations, Payments and Appeals

Benefit Determinations

We, or anyone acting on our behalf, shall determine the administration of Benefits and eligibility for participation in such a manner that has a rational relationship to the terms of the Contract. However, We, or anyone acting on our behalf, have complete discretion to determine the administration of your Benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowed Amount. However, you may utilize all applicable Complaint and Appeal procedures, as outlined later in this section.

You may have some responsibility for the cost of health services under your Contract. Your responsibility may take the form of a Coinsurance percentage, a Deductible, or a Copayment amount. Please see your Schedule of Benefits for the Coinsurance, Deductible and Copayment amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your Coinsurance, Deductible, or Copayment amount directly to the Provider or Hospital or other provider of care. If you have Coinsurance responsibility that is based on a percentage, you will pay your Coinsurance percentage based on the Hospital's or Provider's discounted charge or negotiated amount, or our Maximum Allowed Amount for Providers.

Under certain circumstances, if we pay the healthcare provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Note: We cannot prohibit Non-Network Providers from billing you for the difference in their charge and our Maximum Allowed Amount.

All Benefits for Covered Services will be based on any discounted charge for Hospital service or our Maximum Allowed Amount for Providers services.

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

Benefit Levels There are two levels of Benefits under this Contract:

Network Providers If your claim from a Network Provider is approved, we will pay Benefits directly to the Network Provider. Except for Copayments, Deductibles, and Coinsurance, you are not required to pay any balances to the Provider for Covered Services until after we determine the Benefits we will pay. Benefits will be paid at the Network level of Benefits listed on your Schedule of Benefits.

Non-Network Providers If you receive Covered Services or supplies from a Provider that does not have a written agreement with us, we will determine Benefits based on the Provider's eligibility and licensing. If we do approve your claim, Benefits will be paid at the Non-Network level of Benefits listed on your Schedule of Benefits. You will be responsible for the difference between the Non-Network Provider's charge and our Maximum Allowed Amount, in addition to any applicable Copayment or Deductible. We cannot prohibit Non-Network Provider's from billing you for the difference in their charge and our Maximum Allowed Amount.

If a Network Provider of the same specialty is not reasonably accessible, as defined by state law, services received from a Non-Network Provider will be paid at the higher level of Benefits indicated on your Schedule of Benefits. In this circumstance, please call the number on the back of your ID card to coordinate care through a Non-Network Provider.

How Your Deductible Works

Each Calendar Year before Benefits can be paid for most Covered Services, you must pay your Deductible. Please refer to your Schedule of Benefits.

When you receive Covered Services during the last three months of the Calendar Year and charges for these Covered Services are applied toward that year's Deductible, then these same charges will also be applied toward the Deductible for the following year.

Family Deductible Under family coverage, if the total family expenses for Covered Services exceed two times the individual Deductible, then your family Deductible under this Contract has been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without meeting further Deductibles. One family member may not meet the family Deductible amount. The family Deductible amount must be satisfied by at least two family members.

One Deductible For a Common Accident Under family coverage, if two or more family members are injured in the same accident, only one Deductible will apply for all Covered Services resulting from that accident during a Calendar Year.

Copayments and Coinsurance

Copayments and Coinsurance apply after you have satisfied your Deductible. Please see your Schedule of Benefits for Copayment amounts and Coinsurance amounts and limits. If services are received from a Provider that does not have a written participation agreement with us there may be instances in which you may be responsible for any remaining balances beyond the Maximum Allowed Amount in addition to any applicable Copayment, Coinsurance or Deductible. We cannot prohibit Non-Network Providers from billing you for the difference in their charge and our Maximum Allowed Amount.

Copayments

For some services, your share of the cost is a fixed dollar amount or a percentage. Copayment amounts do count toward the Coinsurance and Out-of-Pocket limits under this Contract. Please see your Schedule of Benefits for applicable Copayment amounts.

Coinsurance For some services, your share of the cost is a percentage which is limited to an annual dollar amount. This is the Coinsurance amount. Once you pay the annual Coinsurance limit, we pay Benefits at 100% of the Maximum Allowed Amount for Covered Services, for the rest of the Calendar Year.

How Your Coinsurance Limit Works Under family coverage, if the total family Coinsurance expenses exceed two times the individual Coinsurance limit, your family Coinsurance limit under this Contract has been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without paying further Coinsurance.

Out-of-Pocket Limits

Your annual out-of-pocket expenses for your Copayments, Deductible and Coinsurance are limited. Please refer to your Schedule of Benefits for Annual Out-of-Pocket Limits that may apply. Once you reach the Annual Out-of-Pocket Limit, no further Copayments, Deductibles or Coinsurance apply for the remainder of the Calendar Year. The Out-of-Pocket Limit does not include your Subscription Charges, amounts over the Maximum Allowed Amount, services covered under any vision plan (if applicable), or charges for non-covered services.

Benefit Maximums

Specific benefit maximums for each covered Member may apply for Mental Health and other services. These maximums are listed on your Schedule of Benefits or in the Contract.

Contract Changes

We may change this Contract at any time provided the changes are in accordance with all applicable laws and we give the Group notice thirty days in advance. After we notify the Group of a change, payment of billed charges indicates the Group's and your acceptance of the change. The Group is responsible for notifying the employee of any Contract changes.

Compliance with Laws

If federal laws or the relevant laws of the state of Maine change, the provisions of this Contract will automatically change to comply with those laws as of their effective dates. Any provision that does not conform with applicable federal laws or the relevant laws of the state of Maine will not be rendered invalid, but will be construed and applied as if it were in full compliance.

Confidentiality

Any information pertaining to your diagnosis, treatment or health obtained from either your Physician, Provider or you will be held in confidence. We may use or disclose this information only to the extent required or permitted by law. Please refer to Anthem BCBS's privacy protection annual notice for our privacy policies and procedures.

Statements and Representations

The statements you make on your application for coverage with us are representations and not warranties.

Acknowledgement of Understanding

By accepting this policy you expressly acknowledge your understanding that this policy constitutes a benefit plan provided through your Group by agreement with Anthem, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The license permits Anthem to use the Blue Cross and Blue Shield service marks in the State of Maine, and that Anthem is not contracting as the agent of the Association.

You also acknowledge that you have not accepted this policy based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem will be held accountable or liable to you for any of Anthem's obligations created under this policy. These acknowledgements in no way create any additional obligations whatsoever on the part of Anthem other than those set forth in this policy.

Annual Reports
Annual reports are prepared and made available to all employees. The annual report contains information about our activities including audited financial statements.

Severability
If any term or provision in this Certificate is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

Benefit Payments

Claims Procedure:

How to Claim Benefits In most instances, Providers will file your claims with us. However, you may need to submit a claim for reimbursement for services from Non-Network Providers.

To receive claim forms, contact your employer or call our Customer Service Department. When you submit your claim, please include originals of all of your bills and retain a copy for your files.

Time Limit for Filing Claims We must receive proof of a claim for reimbursement for a Covered Service no later than 365 days after that service is received. We recognize that there may be special circumstances which would prevent a claim from being submitted within the 365-day time limit. Claims denied for timely filing may be reviewed through the Member Appeal process, which will consider whether the claim was filed as soon as reasonably possible.

Releasing Necessary Information Providers often have information we need to determine your coverage. As a condition for receiving Benefits under this Contract, you or your representative must give us all of the medical information needed to determine your eligibility for coverage or to process your claim.

Non-Transfer of Benefits Your Benefits under this Contract are personal to you. You cannot assign or transfer them to any other person.

Assignment of Payments You may assign Benefits provided for Covered Services to the provider of the care.

Non-Compliance If we do not enforce compliance with any provision of this Contract, we have not waived compliance and are not required to allow non-compliance of that provision or any other provision at any time, in any case.

Examination of Insured To ensure that all claims are valid, we may require the Member to have a physical or mental examination at our expense.

Claims Payment:

This section explains how Benefits for Covered Services will be paid. You will receive maximum Benefits when you receive services from Network Providers. We reserve the right to pay Benefits to another person if so ordered by a court of competent jurisdiction. You have the right to Appeal as outlined later in this section.

Payment of Provider Services

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

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

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

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 unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. This amount can be significant.

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

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

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

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

Customer Service for help in finding a Network Provider or visit www.anthem.com.

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

The Maximum Allowed Amount for your Contract will be one of the following as determined by Anthem:

1. An amount based on our network or non-network provider fee schedule/rate (as required by law), which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, 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 the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

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

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

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

IMPORTANT NOTICE ABOUT YOUR PROVIDER NETWORK AND BENEFITS: There are hospitals, health care facilities, physicians or other health care providers that are not included in this plan's network. Your financial responsibilities for payment of covered services, including "cost shares," such as coinsurance, copayments, and out of pocket maximums may be higher if you use a non-network provider.

Additionally, you may have some cost-sharing for preventive benefits if you do not use a network provider. Please refer to the online provider directory available at Anthem.com to determine if a particular provider is in the network, or contact customer service for assistance.

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

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

Member Cost Share
For certain Covered Services and depending on your Contract, 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 Maximum 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 for your cost share responsibilities and limitations, or call Customer Service to learn how this Contract's benefits or cost share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-covered services. You will 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. Both services specifically excluded by the terms of your plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

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

Authorized Services
In some non-emergency circumstances, such as where there is no Network Provider available for the Covered Service, we may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. If we authorize a Covered Service so that you are responsible for the Network cost share amounts, you may not be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies.. Please contact Customer Service for Authorized Services information or to request authorization.

Example:
You require the services of a specialty Provider; but there is no Network Provider for that specialty in your service area. You contact us in advance of receiving any Covered Services, and we authorize you to go to

an available Non-Network Provider for that Covered Service and we agree that the Network cost share will apply.

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

Because we have authorized the Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and Anthem will be responsible for the remaining balance.

Out-of-State Providers We cannot prohibit out-of-state Providers from billing you any balance remaining after we have made our payment based on the maximum allowable amount except as otherwise provided under the BlueCard program.

Inter-Plan Programs

Out-of-Area Services

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

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

BlueCard® Program

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

Whenever you access covered healthcare services outside Anthem BCBS service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

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

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

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

Under certain circumstances, if **we** pay the healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, **we** may collect such amounts directly from you. You agree that **we have** the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Anthem BCBS Service Area

Your Liability Calculation

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

Exceptions

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

Hospitals Outside of the United States We provide Benefits for Inpatient and Outpatient services in a foreign Hospital. If you obtain Covered Services outside of the United States, in most cases you will have to pay your bill when you leave the Hospital. Please refer to the "Utilization Management" section for details pertaining to authorizations.
When you return home, send the following to us with your claim form:

- A statement of the nature of the illness or injury;
- An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- Your Contract number; and
- The dollar rate of exchange at the time you received the service(s), if possible.

When we receive this information, we will reimburse you for Covered Services according to the terms of this Contract.

Pharmacy Benefit Management

The Pharmacy Benefits available to you under this Plan are managed by a pharmacy benefits management (PBM) company with which we contract to manage your Pharmacy Benefits. The PBM has a nationwide network of retail pharmacies, a mail service Pharmacy, and clinical services that include tier management.

The management and other services provided include, among others, making recommendations to, and updating, the tier listing and managing a network of retail pharmacies and operating a mail service Pharmacy. The PBM, in consultation with Anthem, 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.

Payment for Prescription Drug Claims

To obtain Benefits for Prescription Drugs, present your identification card to any Pharmacy that has an agreement with the PBM, in this or any other state. You must pay the applicable amounts shown on your Schedule of Benefits. The participating Pharmacy will submit the claim for you and the PBM will directly pay the Pharmacy the balance due. Please call Customer Service at the telephone number on your ID card if you have questions about the participation status of a Pharmacy.

If you use a Pharmacy that does not have an agreement with the PBM, or if you do not use your identification card, you must pay the Pharmacy the entire cost for the prescription and submit a claim form for reimbursement. Claim forms are available by contacting a Customer Service Representative.

If you receive Prescription Drugs from a non-participating Pharmacy or if you do not use your identification card, you may receive a reduced benefit. We will reimburse you based on the amount we would have paid to a participating Pharmacy less your share of the cost.

Your financial responsibility (Copayments) will not be reduced by any discounts, rebates or other funds received by the Pharmacy Benefits Manager from drug manufacturers, or similar vendors or funds received by the plan from the Pharmacy Benefits Manager.

Your prescription drug Copayment will be the lesser of your scheduled Copayment amount or the retail price charged for your prescription by the Pharmacy or the Pharmacy Benefits manager that fills your prescription.

No payment will be made by us for any Covered Service unless our negotiated rate exceeds any applicable Copayment for which you are responsible.

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

Prescription Drugs By Mail

To obtain Benefits for Prescription Drugs through the mail order Pharmacy, complete a mail order Pharmacy form, available through our Customer Service Department, and mail it with your prescription. You must enclose the applicable Copayment amount indicated on your Schedule of Benefits.

Coordination of Benefits

All Benefits of the Contract are subject to coordination of Benefits (COB). COB is a formula that determines how Benefits are paid to Members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total Benefits you receive from all contracts do not exceed the cost of Covered Services.

COB sets the payment responsibilities for any contract that covers you, such as:

- Group, individual (also known as non-Group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;

- Group practice, individual practice, and other prepaid Group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- Other insurance that provides medical benefits.

The contract with primary responsibility provides full benefits for Covered Services as if there were no other coverage. The contract with secondary responsibility may provide Benefits for Covered Services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. All Benefits are limited to the contract maximums or to the Maximum Allowed Amount for the services you receive.

When you have duplicate coverage:

- If the other contract does not contain a COB clause or does not allow coordination of benefits with this contract, the Benefits of that contract will be primary;
- If both contracts contain a COB clause allowing the coordination of benefits with this contract, we will determine benefit payments by using the first of the following rules that applies:

1. Non-Dependent/Dependent The Benefits of the contract that covers you as an employee or Subscriber will be determined before the Benefits of the contract that covers you as a Dependent are determined.
2. Dependent Children (Parents Not Legally Separated or Divorced) For claims on covered Dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of Benefits, the rule in this contract will determine the order of Benefits.
3. Dependent Children (Parents Legally Separated or Divorced) In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the Dependent's health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.
4. Active/Inactive Employee The Benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's Dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of Benefits, rule six applies.
5. Continuation of Coverage If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or Subscriber, or as the Dependent of an employee or Subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule six applies.
6. Longer/Shorter Length of Coverage If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or Subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

We reserve the right to:

- Take any action needed to carry out the terms of this section;
- Exchange information with an insurance company or other party;
- Recover the Plan's excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when we decide they're necessary without notifying the covered persons.

Disability

If your Group coverage terminates with us while you are totally disabled, Benefits for Covered Services directly relating to the condition causing total disability remain available to you until you are no longer disabled, you reach any contract maximums, you are discharged as an Inpatient and you are no longer disabled, or six months from the termination of your Group Contract, whichever occurs first. If you have replacement coverage, the replacement coverage will pay as primary coverage during this time, and we will pay as secondary coverage for the covered expenses directly relating to the condition causing total disability.

Under the Contract, disabled means:

- If you were employed, you are unable to work in your regular and customary occupation because of illness or injury;
- If you were not gainfully employed, you are unable to engage in most normal activities of a person of like age in good health.

Our coverage of losses during your total disability has the same limits that apply to employees or Members who are not disabled.

Special Information If You Become Eligible For Medicare

You must notify us if you become eligible for premium free Medicare Part A. Failure to notify us could result in retroactive benefit adjustments if Medicare would have been or is the primary payor. You may choose to continue your coverage once you are eligible for premium free Medicare Part A and Medicare Part B coverage. However, your Contract will not provide Benefits that duplicate any benefits payable under Medicare Part A or Part B. This is true even if you fail to exercise your rights to premium free Medicare Part A and Medicare Part B coverage. If you become eligible for Medicare, you may want to enroll in a Medicare Supplement Plan. Medicare Supplement plans are specifically designed to pay many of the health care costs not covered by Medicare. Because Medicare Supplement plans have limited Enrollment Periods, it is important to evaluate these plans as soon as you are eligible for Medicare.

Subrogation: Payments Resulting from Claim or Legal Action

When another party may have caused or may be responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When we provide health care Benefits for treatment of your injury or illness, we have the right to recover, from any such payment (whether by judgment, suit, compromise, settlement or otherwise) up to the total benefit we paid, on a just and equitable basis. The process of recovering these expenses is called subrogation.

We also have subrogation rights against your own insurance, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy.

Subrogation applies whether any of the payment or settlement is allocated for medical expenses.

If the services related to your illness or injury are covered by a capitation fee, we are entitled to the reasonable cash value of the services.

By accepting plan coverage you agree:

- Your signed application for coverage is your authorization of our right of subrogation;
- To notify us of any event which could result in legal action, a claim against a third party, or a claim against your own insurance;
- To notify us of any payments you receive as a result of legal action, a claim against a third party, or a claim against your own insurance;
- To cooperate with us in exercising our right of subrogation by providing all information requested;

- To sign documents we deem necessary to protect our rights; and
- To do nothing to interfere with our subrogation rights.

If you do not comply with the above, you may be responsible for expenses we incur in enforcing our subrogation rights.

Recovery

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

Complaints and Appeals

Complaints

Our Customer Service Representatives are ready to help Members resolve complaints about claims processing, benefit choices, enrollment, or health care given to you by your Provider. A Customer Service Representative may need to send your complaint to another area for response. The staff that gets the Member complaint will review and quickly give a finding to the Member on the complaint. Anthem will make a good faith effort to get all information quickly. Your Provider may ask by phone, fax or in writing for us to reconsider an adverse determination within one working day after we get the request. The review will be done by the person who made the adverse determination or by a peer if the first person cannot be on hand within one working day.

For first Utilization Review findings, Anthem will make the decision and will let the Covered Person and their Provider know the result within 2 working days after getting all needed information on a proposed hospital stay, treatment or service that calls for a review decision.

If more information is needed, a final decision will be made within thirty (30) days after the added information is received. If your complaint is not resolved to your satisfaction, you may seek help through the Appeal process outlined below. Enrollees may begin a first level Appeal at any time.

Complaints Requiring Immediate Intervention

If you are not happy with a finding on a service, we will work with the health care provider to answer quickly to the concern. This will happen before the need for services, when possible, or within 48 hours after receiving all necessary information.

Concurrent review decisions.

Anthem will make the decision within one working day after getting all needed information.
In the case of a decision to approve a longer stay or more services, Anthem notifies the Member and the Provider rendering the service within one working day. The written notice will include the number of added days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, Anthem notifies the Member and the Provider rendering the service within one working day. The service will continue without liability to the Member until the Member has been told of the finding.

Expedited Appeals.

Anthem has a written process for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures would seriously threaten the life or health of a Member or would risk the Member's ability to get back maximum function. An expedited appeal will be available to, and may be requested by, the Member or the Provider acting for the Member.

Expedited appeals will be reviewed by a clinical peer or peers. The clinical peer/s will not have been part of the first adverse determination.

Anthem will provide expedited review to all requests for a hospital stay, availability of care, continued stay or health care service for a Member who has received emergency services but has not been discharged from a facility.

In an expedited review, all needed information, including Anthem finding, will be shared between Anthem and the Member or the Provider acting for the covered person by telephone, facsimile, electronic means or the quickest method available.

In an expedited review, Anthem will make a decision and notify the Member and the Provider acting for the Member by phone as quickly as the Member's medical condition requires, but not more than 72 hours after the review is begun. If the expedited review is a concurrent review decision of emergency services or of an initially authorized hospital stay or course of treatment, the service will be continued without liability to the Member until the Member has been notified of the finding.

If the first notice was not in writing, Anthem will confirm its finding about the expedited review in writing within 2 working days of providing notice of that finding.

Appeals

Level One Appeal Process
You or your authorized representative, if not satisfied with the first decision or the finding on a complaint, may Appeal the decision to the Anthem Appeals Department. An Appeal may be done orally or in writing and must include specific reasons why you or your representative do not agree with the finding. Appeal of a finding must be sent to within one-hundred-eighty (180) calendar days of the date the finding was made, unless there are special circumstances. We have the right to review the reason for the delay and find out whether they warrant acceptance of the Level One Appeal past the 180-day time frame.

On Appeal, the file will be reviewed. Appeals will be reviewed by an appropriate peer or peers who have not been involved with a prior finding. More information may be submitted by or for the Member, any treating physician, or Anthem. A finding will be made within thirty (30) days after we receive the request for an Appeal.

The decision will include:

- The names, titles and information that qualifies the person or persons evaluating the appeal;
- A statement of the reviewers' understanding of the reason for the Covered Person's request for an Appeal;
- The reviewers' finding in clear terms and the reason in enough detail for the Covered Person to respond to the health carrier's finding;
- A reference to the evidence or information used as the basis for the finding, including the clinical review materials used to make the decision. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Anthem in giving its first Adverse Determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.
- The notice must advise of any additional appeal rights, and the process and time limit for exercising those rights. Notice of external review rights must be provided to the Enrollee and a description of the process for sending in a written request for second level grievance review.

When the finding is made, if the Member, or Member representative, does not agree with the finding, they may submit a voluntary second level Appeal to Anthem, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at **1-800-300-5000.**

If you choose to request a voluntary second level Appeal, you may meet with the review panel in person, or at Anthem's expense by conference call, video conferencing or other appropriate technology to present your concerns with our adverse determination.

On a Level Two Appeal, the entire record will be reviewed.

Appeals of a clinical nature will be reviewed by an appropriate peer or peers who have not been involved with the prior finding. Additional information may be sent in by or for the Member, any treating Physician, or Anthem BCBS. You or your representative may meet with the review panel. If you do not request to meet in person, the decision for second level grievance reviews will be made within 30 calendar days. If you do request to appear in person, the review will be done within forty-five (45) days after we receive the Member's Level Two Appeal. A written decision will be sent to the Member within five (5) working days of the review. Once a final decision has been made by the Second Level Appeal panel, the Member may then ask for an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS.

In any Appeal under this procedure in which a professional medical opinion about a health condition is an issue, you may have the right to an independent second opinion, of a provider of the same specialty, paid for by the plan.

Upon the request of a Member, Anthem shall provide to the Member all information that was used for that finding that is not confidential or privileged.
A Member has the right to:

- Attend the second level review;
- State his or her case to the review panel;
- Submit added material both before and at the review meeting;
- Ask questions of any employee in the meeting; and
- Be assisted or represented by a person of his or her choice.

External Review Process

Your representative is a person who has your written consent to represent you in an external review; a person authorized by law to give consent to request an external review for you; or a family member or your treating physician when you are unable to provide consent to request an external review.

If you, or your representative, do not agree with the outcome of the Level One or Voluntary Level Two Appeal on an Adverse Health Care Treatment Decision by Anthem, you may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity, preexisting condition findings and findings regarding experimental or investigational services. An adverse health care treatment decision is a decision made by us or on our behalf denying payment. The request must be made within 12 months of the date the Member has received the final adverse health care treatment decision of the Level One or Voluntary Level Two Appeal panel.

You or your representative may not request an external review until you have completed Level One of the internal Appeals process unless:

- Anthem BCBS did not make a decision on an Appeal within the time period required or has failed to follow all the requirements of the appeal process as state and federal law require, or the Member has asked for an expedited external review at the same time as applying for an expedited internal appeal;
- Anthem BCBS and you both agree to bypass the internal Appeals process;
- The life or health of the Member is at risk;
- The Member has died; or
- The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written finding must be made by the independent review organization within thirty (30) days after receipt of a completed request for external review from the Bureau of Insurance.

Expedited External Review. An external review finding must be made as quickly as a Member's medical condition requires but no more than 72 hours after the completed request for external review is received if the 30-day time frame above would risk the life or health of the Member or would put the Member's ability to get back maximum function at risk.

An external review finding is binding on Anthem. You, or your representative, may not file a request for a second external review involving the same adverse health care treatment decision for which you have already received an external review decision.

Legal Action Against Anthem BCBS

No legal action may be brought against Anthem BCBS until the Member or the Member's authorized representative has exhausted the complaint and Appeals process outlined above. Any action must be initiated within three (3) years from the earlier of:

- The date of issuance of the underlying adverse Level One Appeal decision; or
- The date of the Level One grievance determination notice.

Section Six
Definitions

This section explains the meaning of some of the words in this Certificate. Other words may be defined in the text.

Accident Care Treatment of an accidental bodily injury sustained by the Member that is the direct cause of the condition for which Benefits are provided and that occurs while the insurance is in force.

Ambulatory Surgery Center A facility that meets both of the following requirements:

- Licensed as an ambulatory surgery center, or is Medicare certified; and
- Meets our standards for participation.

Amendment An addition, change, correction, or revision to the terms and conditions of this Contract.

Annual Out-of-Pocket Limit The limit on the Copayments, Deductible and Coinsurance you pay each year. After you meet the Annual Out-of-Pocket Limit, you pay no further Copayments, Deductible or Coinsurance for the remainder of the calendar year.

Annual Review Date The date set by us and your Group on which the Contract renews each year.

Appeal A request for a review of our initial decision, a decision on a registered complaint, or determination of medical necessity.

Applied Behavior Analysis The design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder Any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Benefits Payments we make on your behalf under this Contract.

Calendar Year The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding Calendar Year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

Certificate The document that specifies the health care Benefits available to Members under this Contract.

Chiropractor A person who is licensed to perform chiropractic services, including manipulation of the spine.

Coinsurance The percentage we pay toward the cost of some Covered Services and the percentage you pay.

Community Mental Health Center An institution that meets both of the following requirements:

- Licensed as a comprehensive level Community Mental Health Center; and
- Meets our standards for participation.

Contract This Certificate, any Amendments, riders, or attached papers; the Group Agreement; your application; and the Schedule of Benefits.

Contract Holder The employer, association, or trust that applies for and accepts this coverage on behalf of its Members.

Copayment A fixed dollar amount or percentage required to be paid by each Member for certain Covered Services under this Contract. Please refer to your Schedule of Benefits for specific information.

Cosmetic Services Medical/surgical procedures or services intended solely to change or improve appearance or to treat emotional, psychiatric, or psychological conditions.

Covered Service Services, supplies or treatment as described in this Certificate. To be a Covered Service the service, supply or treatment must be:

a. Medically Necessary or otherwise specifically included as a benefit under this Certificate.
b. Within the scope of the license of the Provider performing the service.
c. Rendered while coverage under this Certificate is in force.
d. Not Experimental or Investigational or otherwise excluded or limited by this Certificate, or by any Amendment or rider thereto.
e. Authorized in advance by us if such preauthorization is required in this Certificate.

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

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; 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.

Care can be Custodial whether or not it is recommended or performed by a Provider and whether or not it is performed in a facility (e.g. Hospital or Skilled Nursing Facility) or at home.

Day Treatment Patient A patient receiving Mental Health or Substance Abuse care on an individual or Group basis for more than two hours but less than 24 hours per day in either a Hospital, rural Mental Health center, Substance Abuse Treatment Facility, or Community Mental Health Center. This type of care is also called partial hospitalization.

Deductible The amount you may be required to pay each year toward the Maximum Allowed Amount for certain Covered Services before this Contract provides Benefits.

Dental Service Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth include: the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the laminar dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

Dependent The eligible employee's lawful spouse, children and others as outlined in the "Eligibility, Termination and Continuation of Coverage" section of this Certificate.

Diagnostic Service A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Discount Favorable rates or Discounts we have negotiated with Hospitals and other Providers. Members benefit from these rates or Discounts since they are applied prior to calculating your share of costs. discounted charges reduce the expenses paid by us which helps to lower the Contract costs.

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

Durable Medical Equipment Equipment that meets all of the following criteria:

- Can withstand repeated use;
- Is used only to serve a medical purpose;
- Is appropriate for use in the patient's home;
- Is not useful in the absence of illness, injury, or disease; and
- Is prescribed by a Physician.

Durable Medical Equipment does not include fixtures installed in your home or installed on your real estate.

Early Intervention Services Services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

Effective Date The first day of coverage with Anthem Blue Cross and Blue Shield.

Emergency Medical Condition A physical or mental condition, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the physical or Mental Health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part; or

With respect to a pregnant woman who is having contractions:

- That there is inadequate time to safely transfer to another Hospital before delivery; or

- That transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Service Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the Member's physical and/or Mental Health in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part.

Examples of illnesses or conditions that may require Emergency Services include, but are not limited to: heart attack, stroke or severe hypertensive reaction, coma, blood or food poisoning, severe bleeding, shock, obstruction (airway, gastrointestinal or urinary tract), and allergic or acute reactions to drugs.

Enrollment Date The first day of coverage or, if there is a waiting period, the first day of the waiting period.

Enrollment Period The period following your initial eligibility for enrollment.

Experimental or Investigational Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem BCBS determines to be Experimental or Investigational.

Anthem BCBS will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought.

(a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

(i) cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or

(ii) has been determined by the FDA to be contraindicated for the specific use; or

(iii) is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or

(iv) is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or

(v) is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

(b) Any Service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Anthem BCBS. In determining whether a Service is Experimental or Investigational, Anthem BCBS will consider the information described in subsection (c) and assess the following:

(i) whether the scientific evidence is conclusory concerning the effect of the Service on health outcomes;

(ii) whether the evidence demonstrates the Service improves the net health outcomes of the total population for whom the Service might be proposed by producing beneficial effects that outweigh any harmful effects;

(iii) whether the evidence demonstrates the Service has been shown to be as beneficial for the total population for whom the Service might be proposed as any established alternatives; and

(iv) whether the evidence demonstrates the Service has been shown to improve the net health outcomes of the total population for whom the Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information considered or evaluated by Anthem BCBS to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:

(i) published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

(ii) evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

(iii) documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(iv) documents of an IRB or other similar body performing substantially the same function; or

(v) consent document(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vi) the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vii) medical records; or

(viii) the opinions of consulting Providers and other experts in the field.

(d) Anthem BCBS identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Family Planning Agency An agency that meets both of the following requirements:
- Is a delegated Family Planning Agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets our standards for participation.

Freestanding Imaging Center An institution that meets both of the following requirements:
- Licensed (where available) as a Freestanding Imaging Center, freestanding diagnostic center, or freestanding radiology center; and
- Meets our standards for participation.

Freestanding Surgical Facility An institution that meets all of the following requirements:
- Has a medical staff of Physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
- Has equipment for emergency care;
- Has a blood supply;
- Maintains medical records;
- Has agreements with Hospitals for immediate acceptance of patients who need Hospital confinement on an Inpatient basis;
- Is licensed in accordance with the law of the appropriate legally authorized agency; and
- Meets our standards for participation.

Grace Period The 31 days that begin with and follow the due date of an unpaid Subscription Charge.

Group The employer that applies for and accepts this coverage on behalf of its Members.

Home Health Agency An institution that meets both of the following requirements:
- Licensed as a Home Health Agency; and
- Meets our standards for participation.

Hospice A facility that meets both of the following requirements:
- Licensed as a Hospice; and
- Meets our standards for participation.

Hospice Care Services that furnish pain relief, symptom management, and support to terminally ill patients and their families.

Hospital An institution that is duly licensed by the state of Maine as an acute care, rehabilitation or psychiatric Hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Error of Metabolism A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Independent Laboratory An institution that meets both of the following requirements:
- Licensed as an independent medical laboratory; and

- Meets our standards for participation.

Infertility The inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the presence of a demonstrated condition recognized as a cause of Infertility by the American College of Obstetrics and Gynecology, the American Urologic Association, or other appropriate independent professional associations.

Inpatient A registered bed patient who occupies a bed in a Hospital, Skilled Nursing Facility, or residential treatment facility. A patient who is kept overnight in a Hospital solely for observation is not considered a registered Inpatient. This is true even though the patient uses a bed. In this case, the patient is considered an Outpatient.

Inpatient Stay One period of continuous, Inpatient confinement. An Inpatient Stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care Hospital to another acute care Hospital as an Inpatient when medically necessary is part of the same stay.

Late Enrollee A Subscriber or a Dependent family member who requests enrollment under the Contract Holder's Group health plan following the initial Enrollment Period provided under the terms of the plan; or a Subscriber or Dependent family member who enrolls after 31 days following any of the qualifying life events described in the "Eligibility, Termination, and Continuation of Coverage" section of this Contract. A Late Enrollee may only submit an application during the annual Late Enrollee Enrollment Period.

Maintenance Prescription Drug A Prescription Drug that is used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes.

Maintenance Therapy Any treatment, service, or therapy that preserves the Member's level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

Maximum Allowed Amount The maximum amount that we will allow for Covered Services you receive. For more information, see the "Benefit Determinations, Payments and Appeals" section.

Medicaid Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medically Necessary Health Care Health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the Member or Physician or other health care practitioner.

Medicare The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member The Subscriber and all family members who are eligible for coverage and who we accept for coverage under this Contract.

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

Morbid Obesity A condition of persistent and uncontrolled weight gain existing for a minimum of five consecutive years that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

Network Pharmacy Any Pharmacy, located within the United States, acceptable as a Participating Pharmacy by Anthem to provide Covered Drugs to Members under the terms and conditions of this Certificate**.** Also referred to as "Participating Pharmacy".

Network Providers Health care Providers that have a written agreement with Anthem BCBS to furnish health care services under this Contract. Also referred to as Participating Providers.

Network Specialty Pharmacy Any appropriately licensed Pharmacy located within the United States which has entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to render Specialty Drug services and certain administrative functions.

Non-Network Pharmacy Any appropriately licensed Pharmacy, located within the United States that is not a Participating Pharmacy under the terms and conditions of this Certificate. Also referred to as "Non-Participating Pharmacy".

Non-Network Providers Health care Providers that do not have a written agreement with Anthem BCBS to furnish health care services under this Contract. Also referred to as Non-Participating Providers. Providers who have not contracted or affiliated with our designated Subcontractor(s) for the services they perform under this plan are also considered Non-Network Providers.

Orthognathic Surgery A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Outpatient A patient who receives services at a Provider and who is not a registered Inpatient. A patient who is kept overnight in a Hospital solely for observation is considered an Outpatient. This is true even though the patient uses a bed.

Pharmacy Any retail establishment operating under a license and in which a registered pharmacist dispenses Prescription Drugs.

Pharmacy and Therapeutics Committee Anthem's national committee made up of Physicians and other experts in medicine and Pharmacy.

Physician See definition of "Provider."

Prescription Drugs A narcotic or medicine approved by the federal Food and Drug Administration (FDA) for use outside of a Hospital dispensed under a Physician's written order. Prescription Drugs are: required by state law to be dispensed only with a prescription; required by law to display the notice,

"Caution: Federal law prohibits dispensing without a prescription"; any other drug we may approve through our drug approval process.

Prostheses Prostheses are appliances that replace all or part of a body organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider

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

- Acute-care Hospitals
- Skilled nursing facilities
- Rural Health Centers
- Home health agencies
- Ambulatory surgery centers
- Hospices
- Community Mental Health Centers
- Substance Abuse Treatment Facilities
- Licensed pharmacies
- Acute care psychiatric and rehabilitation Hospitals
- Independent laboratories
- Freestanding Imaging Centers
- Family planning agencies
- Durable Medical Equipment Providers
- Infusion Providers
- Other Providers that have written participating agreements with us;
- Other Providers, as required by law.

<u>Physicians</u>

- Doctor of Medicine
- Doctor of Osteopathy

<u>Other Providers:</u>

- Doctor of Optometry
- Doctor of Chiropractic
- Doctor of Podiatry
- Doctor of Dentistry
- Doctor of Psychology
- Licensed Audiologist
- Licensed Psychiatric Nurse Specialist
- Licensed Clinical Social Worker
- Licensed Clinical Professional Counselor
- Licensed Marriage and Family Therapist
- Licensed Pastoral Counselor
- Physical Therapist
- Occupational Therapist
- Speech Therapist

- Registered Nurse
- Licensed Practical Nurse
- Certified Nurse Midwife
- Ambulance Services
- Other Providers that have written participating agreements with us;
- Other Providers as required by law.

Radiation Therapy The use of high energy penetrating rays to treat an illness or disease.

Reconstructive Procedures Procedures performed on structures of the body to improve or restore bodily function or to correct deformity when there is functional impairment resulting from disease, trauma, previous therapeutic process, or congenital or developmental anomalies.

Rural Health Center An institution that meets both of the following requirements:
- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets our standards for participation.

Sitter/Companion A person who provides short-term supervision of Hospice patients during the temporary absence of family members.

Skilled Nursing Facility (SNF) An institution that meets all of the following requirements:
- Licensed as a Skilled Nursing Facility;
- Accredited in whole or in a specific part as a Skilled Nursing Facility for the treatment and care of Inpatients;
- Engaged mainly in providing skilled nursing care under the supervision of a Physician in addition to providing room and board;
- Provides 24-hour-per-day nursing care by or under the supervision of a registered nurse (RN);
- Maintains a daily medical record for each patient;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets our standards for participation.

Specialist Service A service by a Provider practicing in specialty areas such as cardiology, neurology, surgery, and other specialties.

Specialty Drug The term "Specialty Drug" means prescription legend drugs which:
- are approved to treat limited patient populations, indications or conditions;
- are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- have limited availability, special dispensing and delivery requirements, and/or require additional patient support- any or all of which make the Drug difficult to obtain through traditional pharmacies.

Subcontractor An organization or entity that provides particular services in specialized areas of expertise. Examples of Subcontractors include, but are not limited to: Prescription Drugs, Mental Health/ behavioral health and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Subscriber The person who applied for coverage under this Contract and whose application and payment of required Subscription Charges we have accepted.

Subscription Charge The rates established by us as consideration for Benefits offered in this Contract.

Substance Abuse Treatment Facility A residential or nonresidential institution that meets all of the following requirements:

- Licensed or certified as a Substance Abuse Treatment Facility;
- Provides care to one or more patients for alcoholism and/or drug dependency;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets our standards for participation.

Surgical Assistant A Physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified Provider as permitted by law and recognized by us who actively assists the operating surgeon in performing a covered Surgical Service.

Surgical Service A service performed by a Provider acting within the scope of his or her license that is:

- A generally accepted operative and cutting procedure; or
- An endoscopic examination or other invasive procedure using specialized instruments; or
- The correction of fractures and dislocations.

Telemedicine The use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine, or e-mail.

Terminal Illness A Terminal Illness exists if a person becomes ill with a prognosis of 12 months or less to live, as diagnosed by a Physician.

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

Treatment of Autism Spectrum Disorders The following types of care prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analsysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

Utilization Management The process we use to determine the medical necessity, appropriateness, efficacy or efficiency of health care services. Techniques include Inpatient admission review, continued Inpatient Stay review, discharge planning, post admission review, and case management.

Waiting Period The period required by your Group or us before enrollment in this Group health plan is allowed.

Walk-In Center / Retail Health Clinic The terms Walk-In Center and Retail Health Clinic mean a free-standing center providing episodic health services without appointments for diagnosis; care; and treatment.

Section Seven
ERISA Rights

You are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

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

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, you can take steps to enforce the rights explained above. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you a daily penalty fee until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits and Security Administration, U.S. Department of Labor, J.F. Kennedy Federal Building, Room 575, Boston, MA 02203 (617-565-9600) or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

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