

Summary Booklet

(Referred to as “Booklet” in the following pages)

Century Preferred

Important: This is not an insured Benefit Program. The benefits described in this Summary Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Anthem BCBS provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

anthem.com

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.



CENTURY PREFERRED

SUMMARY BOOKLET

PLEASE READ YOUR BOOKLET CAREFULLY

Capital Area Health Consortium
Group # 068965-015, 026, 027, 028
HBP # 001

Important: This is not an insured Benefit Program. The benefits described in this Summary Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Anthem BCBS provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

TABLE OF CONTENTS

INTRODUCTION	1
CENTURY PREFERRED HEALTH CARE BENEFIT PROGRAM	2
BLUECARD PPO PROGRAM	3
MEMBER SERVICES	3
HOW TO OBTAIN LANGUAGE ASSISTANCE	4
IDENTITY PROTECTION SERVICES	4
IMPORTANT NOTICES AND YOUR SCHEDULE OF BENEFITS	5
SCHEDULE OF BENEFITS	5
IMPORTANT NOTES ABOUT YOUR BENEFITS AND COST-SHARES	11
DEFINITIONS	13
MANAGED BENEFITS – MANAGED CARE GUIDELINES	32
INTRODUCTION	32
SELECTING A PRIMARY CARE PHYSICIAN / PROVIDER (PCP)	32
HOW TO ACCESS PRIMARY AND SPECIALTY CARE SERVICES	33
ENHANCED PERSONAL HEALTH CARE PROGRAM	33
YOUR RESPONSIBILITIES WHEN OBTAINING HEALTH CARE – PRIOR AUTHORIZATION	33
REQUESTING PRIOR AUTHORIZATION	34
PRIOR AUTHORIZATION FOR ADMISSIONS	35
CONCURRENT REVIEW	36
PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION	38
MEMBER APPEAL PROCESS	38
COVERED SERVICES – WHAT’S COVERED	39
AMBULANCE SERVICES	40
CLINICAL TRIALS	41
DIABETES EQUIPMENT, EDUCATION, AND SUPPLIES	43
DIAGNOSTIC SERVICES	43
DURABLE MEDICAL EQUIPMENT AND MEDICAL DEVICES, ORTHOTICS, PROSTHETICS, AND MEDICAL AND SURGICAL SUPPLIES	45
HOME CARE SERVICES	46
HOSPICE SERVICES	47
HOSPITAL SERVICES	48
HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW / STEM CELL / CORD BLOOD) SERVICES	50
MATERNITY/FAMILY PLANNING SERVICES	53
MEDICAL EMERGENCY	54
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	55
OFFICE VISITS, DOCTOR, AND SURGICAL SERVICES	56
ORAL SURGERY	59
OTHER PROVISIONS	60
PRESCRIPTION DRUG	61
PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER	62
PREVENTIVE CARE SERVICES	63
PRIVATE DUTY NURSING SERVICES	65
SKILLED NURSING FACILITIES	66
SPECIALIZED FORMULA AND MODIFIED FOODS	66
THERAPY SERVICES	67
URGENT CARE SERVICES	68

EXCLUSIONS AND LIMITATIONS – WHAT’S NOT COVERED.....	69
SUBROGATION AND REIMBURSEMENT.....	75
SUBROGATION.....	75
REIMBURSEMENT	76
YOUR DUTIES.....	77
WORKERS’ COMPENSATION.....	78
AUTOMOBILE INSURANCE.....	79
COORDINATION OF BENEFITS.....	80
APPLICABILITY.....	80
DEFINITIONS.....	80
ORDER OF BENEFIT DETERMINATION RULES	81
EFFECT OF THIS BENEFIT PROGRAM ON THE BENEFITS	83
RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.....	83
FACILITY OF PAYMENT	83
RIGHT OF RECOVERY	84
CLAIMS PROVISIONS	85
MAXIMUM ALLOWED AMOUNT (MAA).....	85
CLAIM PROCEDURES	88
PAYMENT FOR COVERED SERVICES.....	92
CLAIM OVERPAYMENTS	93
CLAIM DENIALS	93
CLAIMS REVIEW.....	94
CLAIM FORMS	94
INTER-PLAN ARRANGEMENTS	95
OUT-OF-AREA SERVICES - OVERVIEW	95
INTER-PLAN ARRANGEMENTS ELIGIBILITY – CLAIM TYPES.....	95
BLUECARD® PROGRAM.....	95
NEGOTIATED (NON–BLUECARD PROGRAM) ARRANGEMENTS	96
SPECIAL CASES: VALUE-BASED PROGRAMS - BLUE CARD® PROGRAM	96
INTER-PLAN PROGRAMS: FEDERAL/STATE TAXES/SURCHARGES/FEES.....	96
NON-PARTICIPATING PROVIDERS OUTSIDE OUR SERVICE AREA	96
BLUECARD GLOBAL CORE ® PROGRAM	96
MEMBER RIGHTS AND RESPONSIBILITIES	98
YOU HAVE THE RIGHT TO:	98
YOU HAVE THE RESPONSIBILITY TO:.....	99
GRIEVANCE AND EXTERNAL REVIEW PROCESS.....	100
RIGHTS AVAILABLE TO MEMBERS	100
OTHER HELPFUL RESOURCES.....	100
IF YOU HAVE A COMPLAINT OR AN APPEAL	101
HOW ARE GRIEVANCES HANDLED?.....	101
STANDARD (NON-URGENT) GRIEVANCE	102
URGENT (EXPEDITED) GRIEVANCES.....	102
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER.....	102
EXTERNAL REVIEW	103
PRESCRIPTION DRUG LIST EXCEPTIONS	104
REQUIREMENT TO FILE AN APPEAL BEFORE FILING A LAWSUIT	104
ELIGIBILITY AND ENROLLMENT – ADDING MEMBERS.....	105
WHO IS ELIGIBLE FOR COVERAGE.....	105

WHEN YOU CAN ENROLL.....	106
ENROLLING DEPENDENT CHILDREN	107
UPDATING COVERAGE AND/OR REMOVING DEPENDENTS	108
NONDISCRIMINATION	108
STATEMENTS AND FORMS	108
TERMINATION AND CONTINUATION OF COVERAGE.....	109
TERMINATION	109
REMOVAL OF MEMBERS	109
CONTINUATION OF COVERAGE UNDER FEDERAL LAW (COBRA)	109
CONTINUATION OF COVERAGE DUE TO MILITARY SERVICE	112
FAMILY AND MEDICAL LEAVE ACT OF 1993	113
GENERAL PROVISIONS.....	114
ASSIGNMENT	114
CARE COORDINATION	114
CLERICAL ERRORS	114
CONFIDENTIALITY AND RELEASE OF INFORMATION	114
CONFORMITY WITH LAW	115
CONTRACT WITH ANTHEM	115
FORM OR CONTENT OF BOOKLET	115
GOVERNMENT PROGRAMS	115
IDENTIFICATION CARDS	115
LIMITATION OF ACTIONS	115
MEDICAL POLICY AND TECHNOLOGY ASSESSMENT	116
MODIFICATIONS	116
NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS	116
PAYMENT INNOVATION PROGRAMS	116
POLICIES AND PROCEDURES	117
PROGRAM INCENTIVES	117
RELATIONSHIP OF PARTIES (EMPLOYER -MEMBER-ANTHEM).....	117
RELATIONSHIP OF PARTIES (ANTHEM AND IN-NETWORK PROVIDERS)	117
RESERVATION OF DISCRETIONARY AUTHORITY	118
RIGHT OF RECOVERY	118
UNAUTHORIZED USE OF IDENTIFICATION CARD.....	118
VALUE-ADDED PROGRAMS	118
VALUE OF COVERED SERVICES	118
VOLUNTARY CLINICAL QUALITY PROGRAMS	119
VOLUNTARY WELLNESS INCENTIVE PROGRAMS	119
WAIVER.....	119
TIME PERIODS	119
OPTIONAL PROVISION(S)	120
PRESCRIPTION DRUG RIDER.....	121
<i>Introduction</i>	<i>121</i>
<i>Pharmacy Benefits Management</i>	<i>121</i>
PRESCRIPTION DRUG DEFINITIONS.....	123
PRESCRIPTION DRUG BENEFITS.....	126
<i>Prior Authorization.....</i>	<i>126</i>
<i>Specialty Pharmacy Network.....</i>	<i>127</i>
<i>Therapeutic Substitution of Drugs.....</i>	<i>127</i>
<i>Participating Pharmacy or Network Specialty Pharmacy Benefits.....</i>	<i>127</i>
<i>Non-Participating Pharmacy or Non-Network Specialty Pharmacy Benefits.....</i>	<i>128</i>
<i>National Pharmacy Network</i>	<i>129</i>
<i>Voluntary Mail Order Program.....</i>	<i>129</i>

<i>Tiers</i>	129
<i>Prescription Drug List</i>	130
<i>Exception Request for a Drug not on the Prescription Drug List</i>	130
<i>Other Provisions</i>	130
PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS	131
GET HELP IN YOUR LANGUAGE	134
IT'S IMPORTANT WE TREAT YOU FAIRLY	137

INTRODUCTION

This Summary Booklet describes generally this Benefit Program, which is funded by **Capital Area Health Consortium** and for which Anthem Blue Cross and Blue Shield (Anthem BCBS) performs various administrative services.

This Summary Booklet is a description of the Benefit Program only, it is neither intended to describe any other health benefit plans the Employer may offer nor by itself intended to be a summary plan description as defined in the Employee Retirement Income Security Act of 1985, as amended (ERISA). In addition, the Employer may have requirements with regard to the administration of the Benefit Program.

The Benefit Program is a self-insured health benefit plan. It is not an insurance policy or underwritten program. This Summary Booklet has been prepared by Anthem BCBS on behalf of and at the direction of the Employer for the purpose of describing the benefits the Employer has agreed to provide to its Employees and their Dependents under the Benefit Program. The Employer is responsible for whether the Summary Booklet completely or accurately describes the Benefit Program.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc., an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and do not assume any financial risk or obligation with respect to claims.

Anthem BCBS performs various administrative services with regard to the Benefit Program as described in the Administrative Services Agreement between Anthem BCBS and the Employer. The Employer has the right to change the benefits under the Benefit Program, subject to the terms specified in the Administrative Services Agreement. A change by the Employer of the benefits described in this Summary Booklet will not be administered by Anthem BCBS unless the terms of the Administrative Services Agreement, including notice to Anthem BCBS of the change, are complied with by the Employer. Accordingly, except as specifically required by the terms of the Administrative Services Agreement, Anthem BCBS shall have no responsibility to perform certain administrative services with regard to benefit changes made by the Employer under the Benefit Program unless they are communicated to Anthem BCBS in the manner prescribed under the Administrative Services Agreement. Please be sure to contact the benefits coordinator at the Employer for more information concerning the Employer's obligations under the Administrative Services Agreement; the Employer's requirements, if any, regarding participation in the Benefit Program; and to obtain a summary plan description of the employee health care benefit plan.

Your Employer has agreed to be subject to the terms and conditions of Anthem's provider agreements which may include Precertification/Prior Authorization and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

A Member's rights to benefits under this Benefit Program are subject to all the terms of the Administrative Services Agreement and Description of Benefits, and such rights shall terminate in accordance with the terms and provisions as specified therein.

All the defined terms used in this Summary Booklet have the meanings ascribed to them herein without reference to any of the definitions contained in the Administrative Services Agreement. The terms of this Summary Booklet shall govern and supersede any previous versions of this Summary Booklet and any outlines or other summaries distributed by the Employer or Anthem BCBS with respect to the Benefit Program.

"You" or "your" refers to the Member, Subscriber, and each covered Dependent, and who is named on the Identification (ID) Card. The Subscriber is the person for whom the Employer has provided coverage through his or her employment. The Dependent Member is a covered Dependent of the Subscriber. The Employer has contracted with us to administer coverage for its group's Subscribers and their Dependent Members. "We," "us," and "our" refer to Anthem Blue Cross and Blue Shield ("Anthem BCBS") as the Claims Administrator. Other terms are defined in the "Definitions" section of the Booklet.

Century Preferred Health Care Benefit Program

This Booklet describes your Century Preferred health care coverage. The Booklet explains the benefits, exclusions, limitations, terms, and conditions of Membership and services and the guidelines which must be followed in order for you to get benefits for Covered Services. The benefits described in this Booklet are equal to or better than those benefits required by State and Federal Mandates. This Booklet replaces and supersedes any Summary Booklet, contract, policy or program of the same or similar coverage that Anthem BCBS may have issued to you prior to the issue date of this Benefit Program. Amendments to this Booklet may occur. The Effective Date of such changes shall be designated by Anthem BCBS and the Employer.

Your Century Preferred Benefit Program is a Preferred Provider Organization (PPO) Benefit Program. This Benefit Program provides service throughout the state of Connecticut. The selection of a primary care Physician (PCP) is recommended. However, this is a managed care program which requires that you observe all guidelines and procedures for obtaining Covered Services.

This Benefit Program offers you the flexibility to determine how you wish to access benefits and obtain Covered Services. There are two levels of coverage under this Benefit Program; In-Network and Out-of-Network coverage. When you visit an Anthem BCBS Century Preferred PPO Provider for Covered Services, you are responsible for any In-Network Cost-Shares. **Your benefits are highest when you visit an Anthem BCBS Century Preferred PPO Provider.**

If you visit an Out-of-Network Provider for Covered Services, you are responsible for any applicable Out-of-Network Cost-Shares or Penalties. You are also responsible for any charges in excess of the Maximum Allowed Amount (MAA).

When establishing the MAA for the Out-of-Network Providers, Anthem BCBS considers industry costs, reimbursement and utilization data indices, including geographically based national reimbursement data.

Please see the Schedule of Benefits for the applicable Cost-Shares and/or Penalties for both options. In addition to listing the Cost-Shares that are your responsibility, this Schedule of Benefits also contains benefit maximums for specific types of coverage.

Your Century Preferred Benefit Program has a statewide network of Participating Physicians, Providers and Hospitals that you may get In-Network services from. For a listing of these Providers, please see the Century Preferred PPO Provider Directory.

Anthem BCBS is not responsible for notifying a Physician's patients when the Provider leaves the Participating Provider network. Although the Century Preferred PPO Provider Directory is updated regularly to keep Members informed of a Provider's participating/non-participating status with Anthem BCBS; we suggest that you check with the Provider as to their participating status prior to getting services.

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

None of Anthem BCBS's employees or the providers with whom it contracts 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 Benefit Program. In addition, Anthem BCBS requires certain 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 Benefit Program.

The Member is entitled to the Covered Services described in the Benefits Section of the Booklet. The Covered Services therein are subject to the terms; conditions; and limitations of the Benefit Program and the Booklet.

BlueCard PPO Program

Anthem BCBS, like other Blue Cross and Blue Shield Licensees, participates in a program called “BlueCard”. See Inter-Plan Arrangements section for additional information.

Member Services

For information and assistance, a Member may call or write Anthem BCBS’s Member Services.

Questions? Member Services is available to explain policies and procedures; and answer questions about available benefits or services.

For information and help, a Member may call or write Anthem BCBS. The telephone number for Member Services is printed on the Member's Identification (ID) Card. The address of Anthem BCBS is:

Anthem Blue Cross and Blue Shield
Member Services
P.O. Box 533
North Haven, Connecticut 06473

Suggestions, Concerns, or Complaints: We hope that you will always be satisfied with the level of service provided to you and your family. We realize, however, that there may be times when problems arise and miscommunications occur which may lead to feelings of dissatisfaction. As a Member, you have the right to express any dissatisfaction, suggestions, or concerns to us. Please contact Member Services to tell us your problem and we will work to resolve it for you as quickly as possible.

Member Services Telephone Number: Toll free in and outside of Connecticut – 1 (800) 545-0948
The Member Services telephone number is also on your Identification (ID) Card.

Home Office Address: You may visit our home office during normal business hours.

Anthem Blue Cross and Blue Shield
108 Leigus Road, Wallingford, CT 06492

Normal Business hours: Monday through Friday – 8:00 a.m. to 5:00 p.m.

When contacting us, please have your group; and ID numbers from your ID Card available. If your questions involve a claim; we will need to know the date of the service, kind of service, the name of the Provider and the charges involved.

How to Obtain Language Assistance

Anthem BCBS is committed to communicating with our Members about their health plan, regardless of their language. Anthem BCBS employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services 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 Member Services. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

Identity Protection Services

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

IMPORTANT NOTICES AND YOUR SCHEDULE OF BENEFITS

CENTURY PREFERRED

In this section you will find an outline of the benefits included in your Benefit Program and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the “Covered Services” and Prescription Drugs Rider section(s) for more details on the Benefit Program’s Covered Services. Read the “Exclusions and Limitations” section for details on Excluded Services.

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

To get the highest benefits at the lowest Out-of-Pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Benefit Program will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the “Claims Provisions” and “Managed Benefits – Managed Care Guidelines sections for more details.

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

Schedule of Benefits

All benefits described below are per member per Benefit Period.

Please see “Important Notices about Your Benefits and Cost-Shares” for additional information about how your Deductible and Out-of-Pocket works, and other important notices pertaining to your benefits, limits, or cost-shares.

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
COST-SHARING SUMMARY		
Deductible	Not Applicable	
Individual		\$200 per member
Family		\$600 per family
Coinsurance After any applicable Deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	Not Applicable	20% Coinsurance

<p>Out-of-Pocket Limit</p> <p>Individual</p> <p>Family</p> <p>Includes all Cost-Shares; Deductible, Coinsurance, and Copayments.</p>	<p>\$6,600 per member</p> <p>\$13,200 per family</p>	<p>\$1,200 per member</p> <p>\$1,600 per family</p>
<p>PREVENTIVE CARE SERVICES</p> <p>This section does not include all preventive services. Certain diagnostic services provided in relation to the preventive and wellness service will require cost-sharing. For any questions related to coverage or cost-sharing of specific services, contact Member Services at the phone number located on the back of your ID card or visit www.Anthem.com.</p>		
<p>Adult Preventive Visit</p>	<p>No Cost-Share</p>	<p>Coinsurance after Deductible is met</p>
<p>Infant / Pediatric Preventive Visit</p>	<p>No Cost-Share</p>	<p>Coinsurance after Deductible is met</p>
<p>Preventive Care Screenings Including but not limited to:</p> <ul style="list-style-type: none"> • Routine gynecological care: pap smear, pelvic exam, and screening for cervical cancer, • Prostate screening, • Breast cancer screening, including Mammography screening, • Colorectal cancer screening, • Routine colonoscopy, • Routine vision screening, • Routine hearing screening 	<p>No Cost-Share</p>	<p>Coinsurance after Deductible is met</p>
<p>OFFICE VISITS, DOCTOR, AND SURGICAL SERVICES</p>		
<p>Primary Care Provider Office Visits Includes services for illness, injury, follow-up care, surgical procedures done in the office, and consultations.</p>	<p>\$15 Copayment per visit</p>	<p>Coinsurance after Deductible is met</p>
<p>Specialist Office Visits Includes surgical procedures done in the office and consultations.</p>	<p>\$20 Copayment per visit</p>	<p>Coinsurance after Deductible is met</p>
<p>Mental Health and Substance Abuse Office Visit Including Office Visits, Outpatient treatment, and in Home treatment.</p>	<p>No Cost-Share</p>	<p>Coinsurance after Deductible is met</p>

Surgical Professional Services A separate professional fee for services performed by a Surgeon or Physician (Specialist) in any setting other than an Office Visit	No Cost-Share	Coinsurance after Deductible is met
Walk-In Center Services	\$15 Copayment per visit	Coinsurance after Deductible is met
Retail Health Clinic	\$15 Copayment per visit	Coinsurance after Deductible is met
Online Visits Live Health On-Line www.LiveHealthOn-Line.com Other Online Visits	\$15 Copayment per visit PCP or Specialist Copayment	Not Applicable Coinsurance after Deductible is met
HOSPITAL / FACILITY SERVICES		
General Hospital - Inpatient Services Including mental health, substance abuse, maternity, infertility, Human Organ and Tissue Transplant Services.	No Cost-Share	Coinsurance after Deductible is met
Skilled Nursing Facility Up to 120 days per Calendar Year.	No Cost-Share	Coinsurance after Deductible is met
Inpatient Rehabilitation Services / Specialty Hospital Up to 60 days per Calendar Year.	No Cost-Share	Coinsurance after Deductible is met
Inpatient Hospice Care Up to 60 days per Calendar Year.	No Cost-Share	Coinsurance after Deductible is met
Residential Treatment Facility	No Cost-Share	Coinsurance after Deductible is met
Outpatient Services Including surgery, infertility, and diagnostic colonoscopy Freestanding / Ambulatory surgical facility Hospital Facility setting	No Cost-Share No Cost-Share	Coinsurance after Deductible is met Coinsurance after Deductible is met
Partial Hospitalization and Intensive Outpatient Services For Mental Health and Substance Abuse treatment.	No Cost-Share	Coinsurance after Deductible is met

DIAGNOSTIC SERVICES		
Advanced Radiology Including MRI, CAT, CT, PET Scans, and other diagnostic services. Free-Standing Facility Outpatient Hospital Facility	 No Cost-Share No Cost-Share	 Coinsurance after Deductible is met Coinsurance after Deductible is met
Laboratory Services Reference Laboratory / Freestanding Facility Outpatient Hospital Facility	 No Cost-Share No Cost-Share	 Coinsurance after Deductible is met Coinsurance after Deductible is met
Non-Advanced Radiology (Diagnostic and X-ray Services) Including x-ray, Breast Tomosynthesis, and other diagnostic services. Freestanding Facility Outpatient Hospital Facility	 No Cost-Share No Cost-Share	 Coinsurance after Deductible is met Coinsurance after Deductible is met
OUTPATIENT REHABILITATIVE SERVICES (THERAPY SERVICES)		
Speech Therapy Up to 50 visits per Calendar Year, limit combined for physical, speech, occupational therapy and chiropractic care.	No Cost-Share	Coinsurance after Deductible is met
Physical Therapy Up to 50 visits per Calendar Year, limit combined for physical, speech, occupational therapy and chiropractic care.	No Cost-Share	Coinsurance after Deductible is met
Occupational Therapy Up to 50 visits per Calendar Year, limit combined for physical, speech, occupational therapy and chiropractic care.	No Cost-Share	Coinsurance after Deductible is met
Chiropractic Care Up to 50 visits per Calendar Year, limit combined for physical, speech, occupational therapy and chiropractic care.	No Cost-Share	Coinsurance after Deductible is met

<p>Allergy Services</p> <p>Allergy Office Visit/Testing</p> <p>Allergy Treatment Injection, Immunotherapy, or other therapy treatments. Up to a maximum of 80 visits over a 3 year period.</p>	<p>\$20 Copayment per visit</p> <p>No Cost-Share</p>	<p>Coinsurance after Deductible is met</p> <p>Coinsurance after Deductible is met</p>
OTHER SERVICES		
<p>Prescription Drugs: The maximum supply of a drug for which benefits will be provided when dispensed under any fill or refill of a prescription is a 34 day supply.</p> <p>Diabetic equipment, drugs and supplies</p>	<p>Not Applicable</p>	<p>Coinsurance after Deductible is met</p>
<p>Durable Medical Equipment (DME) and Prosthetic Devices</p>	<p>No Cost-Share</p>	<p>Coinsurance after Deductible is met</p>
<p>Diabetic Equipment and Supplies</p>	<p>No Cost-Share</p>	<p>Coinsurance after Deductible is met</p>
<p>Home Health Care Services Nursing and therapeutic services limited to 200 visits per Calendar Year.</p> <p>Home health aide services limited to 80 visits that are applicable to the 200 visit limit.</p>	<p>No Cost-Share</p>	<p>20% Coinsurance after \$50 Deductible is met</p>
EMERGENCY AND URGENT CARE		
<p>Ambulance Services</p>	<p>No Cost-Share</p>	<p>Paid as an In-Network Service</p>
<p>Emergency Room Emergency Room Copayment waived if the Member is admitted directly to the Hospital from the emergency room.</p>	<p>\$50 Copayment per visit</p>	<p>Paid as an In-Network Service</p>
<p>Urgent Care Facility A lower level of complexity than emergency care, in a hospital setting.</p>	<p>\$25 Copayment per visit</p>	<p>Paid as an In-Network Emergency Room Service</p>

PRESCRIPTION DRUGS RIDER – RETAIL PHARMACY		
Prescription Drugs will be subject to various day supply and quantity limits Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines. Copayment amounts shown below are based on a 30 day supply per Prescription Order.		
Day Supply Limits		
<ul style="list-style-type: none"> Retail Pharmacy Specialty Pharmacy 	<p>Up to a 34 day supply</p> <p>Up to a 90 day supply</p>	<p>Up to a 34 day supply</p> <p>Up to a 90 day supply</p>
Tier 1 Prescription Drugs	\$10 Copayment per Prescription Order	Paid as In-Network
Tier 2 Prescription Drugs	\$20 Copayment per Prescription Order	Paid as In-Network
PRESCRIPTION DRUGS RIDER – MAIL ORDER PHARMACY		
Prescription Drugs will be subject to various day supply and quantity limits Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines. Copayment amounts shown below are based on a 100 day supply per Prescription Order on Tiers 1 – 2.		
Day Supply Limits		
<ul style="list-style-type: none"> Mail Order (Home Delivery) Pharmacy Specialty Pharmacy 	<p>Up to a 100 day supply</p> <p>Up to a 90 day supply</p>	<p>Not Covered</p> <p>Not Covered</p>
Tier 1 Prescription Drugs	No Cost-Share	Not Covered
Tier 2 Prescription Drugs	No Cost-Share	Not Covered
OTHER		
Person Responsible for Prior Authorization	Primary Care Provider In-Network Physician In-Network Provider	Member (Member is also responsible for Prior Authorization for Professional BlueCard Providers)
Penalty For Failure to Prior Authorize Covered Services.	No Penalty	\$200 Hospital and/or 25% Physician (of Maximum Allowed Amount (MAA))

Important Notes about Your Benefits and Cost-Shares

1. **Benefit Period:** The Benefit Period is the length of time we will cover benefits for Covered Services. The Benefit Period for this Benefit Program is Calendar Year. A Calendar Year Benefit Period starts on January 1st and ends on December 31st. If your coverage ends before the end of the year, then your Benefit Period also ends.
2. **Deductible Notes:**
 - a. When the Deductible applies, you must pay it before any benefits begin. Please see the “Schedule of Benefits” to find out when the Deductible applies.
 - b. Please see the Deductible definition for details on how the Deductible is satisfied.
3. **Coinsurance Reminder:** Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount.
4. **Out-of-Pocket Limit Notes:**
 - a. The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period. It does not include charges over the Maximum Allowed Amount, or amounts you pay for non-Covered Services, or penalties for not getting required Prior Authorization.
 - b. Please see the Out-of-Pocket definition for details on how the Out-of-Pocket is satisfied.
 - c. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate towards each other.
5. **Out-of-Network Reminder -** Out-of-Network Providers may also bill you for any charges that exceed the Benefit Program’s Maximum Allowed Amount.
6. **Primary Care Physician/Provider (PCP):** Each Member should pick a PCP for routine physicals and to help when you are ill or need follow-up care after you receive Emergency Services. A referral from your Primary Care Provider is not required. Please see “How Your Plan Works” for more details.
7. In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.
8. Some services must be approved through prior authorization or precertification. Please see “Managed Benefits – Managed Care Guidelines” for details.
9. **Colonoscopies -** A maximum of 1 Cost-Share is applied per Member per Calendar Year for Colonoscopies.
10. **Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies:**
 - a. The cost-shares listed in the “Schedule of Benefits” only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.
 - b. **Hearing Aid Coverage:** Up to 1 medically necessary (standard) hearing aid per Member per hearing impaired ear every 24 months.
 - c. **Wigs (needed after Cancer Treatment):** Up to 1 wig per Member per Calendar Year.

11. **Inpatient Services - Newborn / Maternity Stays:** If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.
12. **Outpatient Rehabilitative Services (Therapy Services):**
 - a. Any limits for physical, occupational, and speech therapy will not apply to Autism Spectrum Disorder services.
 - b. No Cost-Shares apply for Early Intervention services (Birth to Three Program) or Autism Spectrum Disorder Behavioral Therapy.
 - c. Cardiac rehabilitation therapy available up to 36 visits per cardiac episode.
13. **Prescription Drug Rider Retail Pharmacy and Mail Order Benefits**
 - a. Each Prescription Drug fill or refill will be subject to a cost-share (e.g., Copayment / Coinsurance) as described in the “Schedule of Benefits”. If your Prescription Order includes more than one Prescription Drug, a separate cost-share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost-share or the Maximum Allowed Amount.
 - b. **Specialty Pharmacy Copayments / Coinsurance:** Please note that In-Network Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see “Specialty Pharmacy” in the section “Prescription Drug Rider” for further details. If you do not use the Specialty Pharmacy, benefits will be covered at the Out-of-Network level.
14. **Private Duty Nursing** – Up to \$15,000 per Member per Calendar Year.
15. **Professional Services Notes:** Some Physicians and Specialists charge a separate fee for the services they render in addition to a separate fee for the facility where the services are provided.
 - a. **Professional Services.** The separate fee for services the Physician or Provider renders will be subject to the applicable Professional Services Cost-Share as shown on the Schedule of Benefits.
 - b. **Facility Services.** The separate fee for services the Facility renders will be subject to the applicable outpatient or inpatient Facility Cost-Share as shown on the Schedule of benefits.

DEFINITIONS

Many words used in this Booklet have special meanings (e.g. Employer, Covered Services, Medically Necessary). These words are capitalized throughout this Booklet and are defined in this "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield (Anthem BCBS or Anthem) as the Claims Administrator. The words "you" and "your" mean the Member, Subscriber, and each covered Dependent.

ACTIVELY AT WORK:

The term Actively At Work means the employee must work at the Employer's place of business or at such place(s) as normal business requires. The employee must perform all duties of the job as required of an employee and work the minimum number of hours required per week on a regularly scheduled basis. Eligible employees who do not satisfy the criteria, solely due to a health-related reason, are considered Actively At Work for purposes of initial eligibility under the Benefit Program.

ACUTE PSYCHIATRIC CARE:

The term Acute Psychiatric Care means psychotherapy provided on an individual or group basis by a Physician or health care team under the supervision of a Physician.

ADMINISTRATIVE SERVICES AGREEMENT:

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

ADMISSION:

The term Admission means the period from the date the Member enters the Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice or other Inpatient Facility as an Inpatient until the date of discharge. When counting days of Inpatient services, the date of entry and date of discharge are combined to count together as one day.

Elective Admission: The term Elective Admission means an Inpatient Admission which is Medically Necessary and scheduled in advance where the Member does not require immediate medical treatment to prevent death, disability or serious impairment of bodily part or function.

ANTHEM BCBS:

The term Anthem BCBS means Anthem Health Plans, Inc. doing business as Anthem Blue Cross and Blue Shield, an independent licensee of the Blue Cross and Blue Shield Association or its agents, representatives, contractors, subcontractors or affiliates.

AUTHORIZE:

The term Authorize (Authorized) means that approval has been obtained from Anthem BCBS for the Emergency Admission of a Member to a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility or Hospice, when required under the terms of this Benefit Program.

AUTHORIZED SERVICE(S):

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Cost-shares (Deductible, Coinsurance, and/or Copayment(s)) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see the "Claims Provisions" and the "2015 Changes and Mandates Amendment" sections for more details.

AUTISM BEHAVIORAL THERAPY PROVIDER:

Means Behavioral Therapy provided or under the supervision of a behavior analyst certified by the Behavior Analyst Certification Board; a licensed physician, or a licensed psychologist. “Supervision” means at least 1 hour of face-to-face supervision of the Autism Services Provider for each ten hours of Behavioral Therapy provided by the supervised certified assistant behavior analyst or behavior therapist.

AUTISM SPECTRUM DISORDERS:

“Autism spectrum disorders” means the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders”. The results of an autism spectrum diagnosis shall be valid for a period of twelve months unless the Member’s licensed physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of the Member’s diagnosis.

BEHAVIORAL THERAPY:

The term Behavioral Therapy means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are: (A) Provided to children less than twenty-one years of age, and (B) provided or under the supervision of an Autism Behavioral Therapy Provider.

BENEFIT PERIOD:

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

BENEFIT PROGRAM:

The term Benefit Program means the program of health care benefits that is identified on the cover page of the Booklet and described herein. The Benefit Program may be referred to as “Plan” in this Booklet.

BIOSIMILAR(S):

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

BIRTHCENTER:

The term Birthcenter means a facility separate from a Hospital which provides room, board and Special Services related to the management of normal childbirth. Synonymous terms are Birthing Center and Childbirth Center.

BOOKLET:

This document (also called the Benefit Booklet), which describes the terms of your benefits while you are enrolled under the Plan.

BRAND NAME DRUGS:

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

CALENDAR YEAR:

The term Calendar Year means a period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

CASE MANAGEMENT:

The term Case Management means the process of evaluating and arranging for Medically Necessary treatment for patients, identified through the use of one or more managed care programs.

CENTERS OF EXCELLENCE (COE) NETWORK:

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

CLAIMS ADMINISTRATOR:

The company the Employer chose to administer its health benefits. Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

CLINICAL PEER(S):

The term means a physician or other health care professional who

1. holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
2. for an urgent care review concerning:
 - a. a child or adolescent substance use disorder or a child or adolescent mental disorder, holds
 - a national board certification in child and adolescent psychiatry; or
 - a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable, or
 - b. an adult substance use disorder or an adult mental disorder, holds
 - a national board certification in psychiatry; or
 - a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

A review for a substance use disorder with or without a co-occurring mental disorder, or for a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep a Member from requiring an inpatient setting are considered an urgent care request.

CLINICAL TRIAL:

The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment, or palliation, or therapeutic intervention for the prevention of cancer, or disabling, or life-threatening chronic disease, in human beings ,except that a clinical trial for the prevention of cancer, or disabling, or life-threatening chronic disease, is eligible for coverage only if it involves a therapeutic intervention and is conducted at multiple institutions. A Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved as outlined in the “Clinical Trials” subsection of the “Covered Services – What’s Covered section.

COINSURANCE:

The term Coinsurance means a fixed percentage of the Maximum Allowed Amount for Covered Services which the Member is required to pay as specified in the Schedule of Benefits.

CONCURRENT REVIEW:

The term Concurrent Review means a process to monitor all Inpatient Admissions to determine its continued Medical Necessity, starting from the assignment of the initial Prior Authorization of days and continuing to the Member’s discharge.

CONTROLLED SUBSTANCES:

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

COPAYMENT:

The term Copayment means a fixed amount which the Member is required to pay for Covered Services. This fee is payable by a Member for certain Covered Services at the time that those services are rendered. Copayments are listed in the Schedule of Benefits and can vary by the type of Covered Service you receive.

COST-SHARE:

The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

COVERED SERVICE(S):

The term Covered Service means services, supplies or treatment as described in this Booklet. To be a Covered Service, the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Booklet;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Booklet is in force;
- Not Experimental or Investigational or otherwise excluded or limited by the Booklet;
- Authorized in advance by Anthem BCBS if such Precertification is required under the Booklet.

COVERED TRANSPLANT PROCEDURE:

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

CUSTODIAL CARE:

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

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

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

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

DEDUCTIBLE:

The term Deductible means the amount you must pay for certain Covered Services in a Benefit Period, before benefits begin under this Benefit Program. For example, if your Deductible is \$1,000, your Benefit Program won't begin to pay Covered Services that apply to the Deductible until you meet the \$1,000 Deductible. Services that have a Deductible are listed in the Schedule of Benefits.

Your Benefit Program has two types of Deductible, the individual and family Deductibles. If you are the only person on your Benefit Program, then the individual Deductible applies. If your Benefit Program includes you and other family members then both types of Deductibles may apply to you. When anyone on the Benefit Program has a health care expense, the money you pay toward the Deductible is credited to both the individual and family Deductibles. The Deductible is considered satisfied for any one member when an individual satisfies his or her individual Deductible, prior to receiving benefits that are subject to the Deductible. The Benefit Program also begins to pay benefits that are subject to the Deductible for the entire family, when the amounts collectively paid by

everyone in the family meet the family Deductible, even if none of the family members has met the individual Deductible.

DEPENDENT:

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

DESCRIPTION OF BENEFITS:

The term Description of Benefits means the document which describes for the Employer the Benefit Program.

DESIGNATED PHARMACY PROVIDER:

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

DOCTOR:

Please see the definition of "Physician".

EFFECTIVE DATE:

The date your coverage begins under this Plan.

EMERGENCY CONDITION:

A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

EMERGENCY SERVICES:

A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. This definition is not intended to limit the scope of services to treat an Emergency Condition otherwise covered under the Benefit Program.

EMPLOYEE:

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

EMPLOYER:

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

ENROLLMENT DATE:

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

EXPERIMENTAL OR INVESTIGATIONAL:

The term Experimental or Investigational means 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 in its sole discretion to be Experimental or Investigational.

- A. 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.

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

- 1. 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
 - 2. Has been determined by the FDA to be contraindicated for the specific use; or
 - 3. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
 - 4. Is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function; or
 - 5. 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:
 - 1. Whether the scientific evidence is conclusory concerning the effects of the service or health outcomes;
 - 2. 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;
 - 3. 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;
 - 4. Whether the evidences demonstrates the service has been shown to improve the net health outcomes of the total population of 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:
 - 1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
 - 2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

3. 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
 4. Documents of an IRB or other similar body performing substantially the same function; or
 5. 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
 6. 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
 7. Medical records; or
 8. The opinions of consulting providers and other experts in the field.
- D. Anthem BCBS has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply is Experimental or Investigational.

Notwithstanding the above, services or supplies will not be considered Experimental if they have successfully completed a Phase III clinical trial of the Federal Food and Drug Administration, for the illness or condition being treated, or the diagnosis for which it is being prescribed.

In addition, services and supplies for Routine Patient Care Costs in connection with a Cancer Clinical Trial will not be considered Experimental.

FACILITY:

A facility including but not limited to, a Hospital, Chemical Dependency Treatment Facility, Residential treatment Facility, Skilled Nursing Facility, Home health Care Agency, or mental health facility, as defined in this Booklet. The Facility must be licensed, registered and approved by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) as applicable, and/or meet specific rules set by us (Anthem BCBS).

A Facility can either be In-Network (also referred to as a Participating), or Out-of-Network, (also referred to as a Non-Participating).

1. **In-Network Facility:** The term In-Network Facility, also referred to as Participating Facility, means a Facility designated and accepted as an In-Network Facility by Anthem BCBS to provide Covered Services to Members under the terms of the Benefit Program.
2. **Out-of-Network Facility:** The term Out-of-Network Facility, also referred to as Non-Participating Facility, means any appropriately licensed Facility which is not an In-Network Facility under the terms of the Benefit Program.

FEE(S):

The amount you must pay for coverage under this Plan.

FREESTANDING PROVIDER:

A Provider (excluding Hospitals) that is not part of or owned by a Hospital and bill independently (i.e. not under a hospital's name or ID number.) Providers such as Ambulatory Surgery Centers, Radiology Providers and Reference Laboratories meet these criteria and are considered "freestanding." Each participating facility and provider type is subject to specific licensing, accreditation and credentialing requirements. These independent entities provide health

care services such as laboratory tests, surgery, radiology and other services and are typically lower cost options for patients.

GENERIC DRUGS:

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

HOME HEALTH CARE AGENCY:

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

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

HOSPICE:

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

HOSPITAL:

The term Hospital means an institution which provides 24 hour continuous services to confined patients and whose chief function is to provide diagnosis and therapeutic facilities for the surgical and medical diagnosis, treatment or care of injured or sick persons. A professional staff of licensed Physicians and surgeons must provide or supervise the services.

A Hospital must be licensed and operated as required by law, which has:

- Room, board, and nursing care;
- A staff with one or more Doctors on hand at all times;
- 24 hour nursing service;
- All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
- Is fully accredited by The Joint Commission.

The institution must provide General Hospital and major surgical facilities and services or specialty services.

- **General Hospital:** The term General Hospital means a Hospital which is licensed as such by the State of Connecticut and has appropriate accreditation from the Joint Commission.

If out-of-state, a General Hospital must have equivalent licensure and accreditation.

- **Specialty Hospital:** The term Specialty Hospital means a Hospital which is not a General Hospital but which is licensed by the State of Connecticut as a certain type of Specialty Hospital and has appropriate accreditation from the Joint Commission.

If out-of-state, a Specialty Hospital must have equivalent licensure and accreditation.

A Hospital can either be In-Network (also referred to as a Participating), or Out-of-Network (also referred to as a Non-Participating).

- **In-Network Hospital:** The term In-Network Hospital, also referred to as Participating Hospital, means a Hospital designated and accepted as an In-Network Hospital by Anthem BCBS to provide Covered Services to Members under the terms of the Benefit Program.

- **Out-of-Network Hospital:** The term Out-of-Network Hospital, also referred to as Non-Participating Hospital, means any appropriately licensed Hospital which is not an In-Network Hospital under the terms of the Benefit Program.

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

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care

IDENTIFICATION CARD (ID Card):

The card given to you showing your Member identification, Group numbers, and the plan you have.

INFERTILITY:

Infertility is the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period.

IN-NETWORK OPTION:

The term In-Network Option means that Covered Services are obtained from any Participating Physicians, Participating Hospital, Participating Facility, or Participating Provider. A participating Provider has a contract, either directly or indirectly, with us (Anthem BCBS), or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see “Managed Benefits – Managed Care Guidelines” for more information on how to find an In-Network Provider for this Plan.

IN-NETWORK TRANSPLANT PROVIDER:

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

INPATIENT:

The term Inpatient means a Member who occupies a bed in a Hospital or other 24 hour care facility, receives board as well as diagnosis, care or treatment and is counted as an Inpatient at the time of a Hospital or 24 hour care facility census.

INPATIENT FACILITY:

The term Inpatient Facility means a facility other than a Hospital that provides board as well as diagnosis, care or treatment on a 24 hour basis to patients such as a Skilled Nursing Facility, Hospice, Substance Abuse Treatment Facility, Sub-acute Care Facility and Residential Treatment Facility.

INTENSIVE IN-HOME BEHAVIORAL HEALTH PROGRAM:

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

INTENSIVE OUTPATIENT PROGRAM:

Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

INTERCHANGEABLE BIOLOGIC PRODUCT:

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

LEARNING DISABILITY:

The term Learning Disability means a disorder in one or more of the basic psychological processes involved in understanding or in using spoken or written language. This may be manifested in disorders of learning, thinking, talking, reading, writing, spelling, arithmetic or social perception.

LICENSED OCCUPATIONAL THERAPIST:

The term Licensed Occupational Therapist means a therapist who is licensed by the State of Connecticut. If out of state, a therapist must have equivalent licensure.

LICENSED PHYSICAL THERAPIST:

The term Licensed Physical Therapist means a therapist who is licensed by the State of Connecticut. If out of state, a therapist must have equivalent licensure.

LICENSED SPEECH PATHOLOGIST:

The term Licensed Speech Pathologist means a therapist who is licensed by the State of Connecticut to render services referred to by Anthem BCBS as Speech Therapy. If out of state, a speech pathologist must have equivalent licensure.

MAINTENANCE CARE:

The term Maintenance Care means treatment provided for the Member's continued well-being by preventing deterioration of the Member's chronic clinical condition; and maintenance of an achieved stationary status which is at a point where little or no measurable objective improvement in musculo-skeletal function can be effectuated despite therapy.

MAINTENANCE PHARMACY:

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90 day supply of Maintenance Medication.

MAINTENANCE PRESCRIPTION DRUG:

The term Maintenance Prescription Drug means a 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.

MAXIMUM ALLOWED AMOUNT (MAA):

The term Maximum Allowed Amount (MAA) means the maximum payment that we will allow for Covered Services. For more information, see the "Claims Provisions" section.

MEDICAL EMERGENCY:

The term Medical Emergency means the onset of an Emergency Condition which requires Emergency Services as a result of a serious illness or injury which requires emergency medical treatment, or the onset of symptoms of sufficient severity that a Member reasonably believes that emergency medical treatment is needed.

MEDICALLY NECESSARY (MEDICALLY NECESSARY CARE, MEDICAL NECESSITY):

The terms Medically Necessary (Medical Necessary Care, Medical Necessity) mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

For the purpose of this subsection "not more costly" means services are cost-effective compared to alternative interventions, including no intervention. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

MEDICARE:

The term Medicare means Title XVIII of the Social Security Act of 1965, as amended.

MEMBER:

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

MENTAL HEALTH AND SUBSTANCE ABUSE:

The term Mental Health and Substance Abuse means 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. Please see the Mental Health and Substance Abuse Services subchapter of the Covered Services - What's Covered section.

MOBILE FIELD HOSPITAL:

The term Mobile Field Hospital means a modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event; or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure and is licensed as such by the State of Connecticut.

NETWORK SPECIALTY PHARMACY:

The term Network Specialty Pharmacy means any appropriately licensed Pharmacy which has entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to render Specialty Drug services and certain administrative functions.

NEW FDA APPROVED DRUG PRODUCT OR TECHNOLOGY:

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

New FDA Approved Drug Product or Technology does not include:

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

NON-NETWORK SPECIALTY PHARMACY:

The term Non-Network Specialty Pharmacy means any appropriately licensed Pharmacy which has not entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to provide Specialty Drug services and certain administrative functions.

NON-PARTICIPATING PHARMACY:

The term Non-Participating Pharmacy means any appropriately licensed Pharmacy that is not a Participating Pharmacy under the terms and conditions of the Prescription Drug Rider.

OPEN ENROLLMENT:

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

OUT-OF-NETWORK OPTION:

The term Out-of-Network Option means that Covered Services are obtained from any Non-Participating Physician, Non-Participating Hospital, Non-Participating Facility, or Non-Participating Provider. A Non-Participating Provider does not have an agreement or contract with Us (Anthem BCBS) or our subcontractor(s), to give services to our Members through a negotiated payment arrangement. You will have a higher Cost-Share and be responsible for the difference between the Maximum Allowed Amount (MAA) and charge when you go Out-of-Network.

OUT-OF-NETWORK TRANSPLANT PROVIDER:

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

OUT-OF-POCKET LIMIT (formerly known as Cost-Share Maximum):

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. All the Cost-Shares you pay during a Benefit Period accumulate to the Out-of-Pocket Limit and once satisfied you pay no additional Deductible, Coinsurance, or Copayments for that Benefit Period.

Your Benefit Program has two types of Out-of-Pocket Limit, the individual and family Out-of-Pocket Limits. If you are the only person on your Benefit Program, then the individual Out-of-Pocket Limit applies. If your Benefit Program includes you and other family members then both types of Out-of-Pocket Limits may apply to you. When anyone on the Benefit Program has a health care expense, the money you pay toward the Out-of-Pocket Limit is credited to both the individual and family Out-of-Pocket Limits. The Out-of-Pocket Limit is considered satisfied for any one member when he or she satisfies his or her individual Out-of-Pocket. The Out-of-Pocket Limit is considered satisfied for the family when the amounts collectively paid by everyone in the family meets the family Out-of-Pocket Limit. Together each family member may contribute to the family Out-of-Pocket Limit, but no family member will contribute more than their individual Out-of-Pocket Limit, and other family members may not need to contribute at all towards the Out-of-Pocket Limit.

In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate towards each other.

The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, charges for health care that your Benefit Program doesn’t cover, penalties, or the exceptions listed in your “Schedule of Benefits”. Please see the “Schedule of Benefits” for details on your Out-of-Pocket Limit amount, and all other Cost-Share amounts.

OUTPATIENT:

The term Outpatient means that the Member receives services in a Hospital emergency room, Physician’s office, or ambulatory surgical facility and leaves in less than 24 hours.

PARTIAL HOSPITALIZATION:

Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

PARTICIPATING PHARMACY:

The term Participating Pharmacy means a Pharmacy acceptable as a Participating Pharmacy by Anthem BCBS, or its pharmacy benefits manager designee, to provide Covered Drugs to Members under the terms and conditions of the Prescription Drug Rider.

PENALTY (PENALTIES):

The term Penalty (Penalties) means that amount the Member must pay when Prior Authorization is not obtained; or for a Medical Emergency Admission which is not Authorized by Anthem BCBS within two business days.

PHARMACY:

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

PHARMACY AND THERAPEUTICS (P&T) PROCESS:

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

PHYSICIAN:

The term Physician means any licensed doctor of medicine (M.D.), osteopathic Physician (D.O.), dentist (D.D.S./D.M.D.), podiatrist (Pod. D/D.S.C./D.P.M.), doctor of chiropractic (D.C.), naturopath (N.D.), optometrist (O.D.) or psychologist (Ph.D./Ed.D/PsyD.) who is licensed to practice in the state in which services are rendered.

A Physician can either be In-Network (also referred to as a Participating), or Out-of-Network, (also referred to as a Non-Participating).

- **In-Network Physician:** The term In-Network Physician, also referred to as Participating Physician, means a Physician designated and accepted as an In-Network Physician by Anthem BCBS to provide Covered Services to Members under the terms of the Benefit Program.
- **Out-of-Network Physician:** The term Out-of-Network Physician, also referred to as Non-Participating Physician, means any appropriately licensed Physician which is not an In-Network Physician under the terms of the Benefit Program.

PLAN:

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

PLAN ADMINISTRATOR:

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. The Plan Administrator is not the Claims Administrator.

PLAN SPONSOR:

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. The Plan Sponsor is not the Claims Administrator.

PLAN YEAR:

A period of 12 consecutive months beginning on the initial effective date of your Employer's Benefit Program, and 12 consecutive months thereafter beginning on each renewal date of your Employer's Benefit Program.

PRECERTIFICATION:

The term Precertification means a required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

PRESCRIPTION DRUG(S) (Also referred to as Legend Drug(s)):

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription."

This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin, diabetic supplies, and syringes.

PRESCRIPTION ORDER:

A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

PRIMARY CARE PHYSICIAN (PCP):

A Participating Physician who gives or directs health care services. The Physician may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Benefit Program. A Primary Care Physician (PCP) supervises, directs and gives initial care and basic medical services to you, and is in charge of your ongoing care.

PRIMARY CARE PROVIDER (PCP):

A Physician, nurse practitioner, Advanced Practice Registered Nurse (APRN), clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Benefit Program, who gives, directs, or helps you get a range of health care services. Please also see "Primary Care Physician" and "Primary Care Services".

PRIMARY CARE SERVICES:

The term Primary Care Services means services rendered by a Physician, or Advanced Practice Registered Nurse (APRN), or other appropriately licensed or certified health care professional whose primary medical practice area is: family medicine, general practice, internal medicine or pediatric medicine. Primary Care Services includes any reference to Primary Care Physician found throughout your Booklet.

PRIOR AUTHORIZATION (PRIOR AUTHORIZED):

The term Prior Authorization means that prior approval has been obtained from Anthem BCBS, which enables a Member to receive benefits for certain Covered Services.

PROOF:

The term Proof means any information that may be required by Anthem BCBS in order to satisfactorily determine a Member's eligibility or compliance with any provision of this Benefit Program.

PROSTHETIC DEVICE:

The term Prosthetic Device means any device which replaces all or part of a body organ (including contiguous tissues), or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the body.

PROVIDER:

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

A Provider can either be In-Network (also referred to as a Participating), or Out-of-Network (also referred to as a Non-Participating).

- **In-Network Provider:** The term In-Network Provider, also referred to as Participating Provider, means a Provider designated and accepted as an In-Network Provider by Anthem BCBS to provide Covered Services to Members under the terms of the Benefit Program.
- **Out-of-Network Provider:** The term Out-of-Network Provider, also referred to as Non-Participating Provider, means any appropriately licensed Provider which is not an In-Network Provider under the terms of the Benefit Program.

RESIDENTIAL TREATMENT FACILITY (Residential Treatment Center):

The term Residential Treatment Facility means a treatment center, which provides residential care and individualized and intensive treatment.

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

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

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

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

RIDER:

The term Rider means an additional benefit of this Benefit Program, which has been purchased by the Employer.

ROUTINE PATIENT CARE COSTS:

Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Please see the “Clinical Trials” subsection of the “Covered Services - What’s Covered” section for details.

SERVICE AREA:

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

SKILLED NURSING FACILITY:

The term Skilled Nursing Facility means any institution that:

- accepts and charges for patients on an Inpatient basis;
- is primarily engaged in providing skilled nursing care, rehabilitative and related services to patients requiring medical and skilled nursing care;
- is under the supervision of a licensed Physician;
- provides 24 hour a day nursing service under the supervision of a registered nurse; and
- is not a place primarily for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, Custodial Care or acute Inpatient level of care.

SPECIAL ENROLLMENT (SPECIAL ENROLLMENT PERIOD):

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

SPECIAL SERVICES:

The term Special Services means services and supplies, rendered by a health care facility in relation to the illness or injury for which a Member is an Inpatient.

SPECIALIST (SPECIALTY CARE PHYSICIAN \ PROVIDER (SCP)):

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

SPECIALIST SERVICES:

Services rendered by a Physician or other appropriately licensed or certified health care professional whose medical practice area is in specialty areas such as cardiology, neurology, surgery and other medical specialties. Specialist Services are for services other than Primary Care Services and are provided by Providers other than your Primary Care Physician or Primary Care Provider (PCP).

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.

STABILIZE:

The term “stabilize” means; With respect to an emergency medical condition - To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

With respect to a pregnant woman who is having contractions, the term “stabilize” also means to - To deliver (including the placenta), if there is inadequate time to effect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

SUBACUTE CARE FACILITY:

The term Subacute Care Facility means a facility that is generally engaged in providing subacute care services, is licensed by the State of Connecticut as a chronic and convalescent nursing home and has appropriate accreditation from the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

SUBCONTRACTOR:

The term Subcontractor means an entity with whom Anthem BCBS may subcontract particular services to such as organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and 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 Anthem BCBS's behalf.

SUBSCRIBER:

An employee of the Employer who is eligible for and has enrolled in the Plan.

SUBSTANCE ABUSE CARE:

The term Substance Abuse Care means services to treat alcoholism or drug dependency.

SUBSTANCE ABUSE TREATMENT FACILITY:

The term Substance Abuse Treatment Facility means a facility which is established primarily to provide 24 hour Inpatient treatment of substance abuse and licensed for such care by the State of Connecticut Department of Public Health and Addiction Services.

SUMMARY BOOKLET:

The term Summary Booklet means the document provided to you which describes the benefits, terms and conditions applicable to the Benefit Program.

TOTAL DISABILITY (OR TOTALLY DISABLED):

Because of an injury or disease the Member is unable to perform the duties of any occupation for which he or she is suited by reason of education, training or experience.

TRANSPLANT BENEFIT PERIOD:

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

URGENT CARE SERVICES:

The term Urgent Care Services means treatment or care of a non-life-threatening illness or injury that requires immediate medical attention to minimize severity and prevent complications. Urgent Care is a lower level of complexity than emergency care, in a hospital setting.

URGENT CARE FACILITY:

The term Urgent Care Facility means a Facility or delivery system within the Emergency Department or a Free Standing Medical Center licensed to take emergency transports, from whom Urgent Care services may be obtained. Urgent Care is a lower level of complexity than emergency care, in a hospital setting.

UTILIZATION REVIEW:

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

WALK-IN CENTER:

The term Walk-In Center means a free-standing center providing episodic health services without appointments for: diagnosis; care; and treatment.

WELL NEWBORN:

The term Well Newborn means an infant who:

1. weighs more than 5 pounds; or
2. in the opinion of the attending Physician, does not have any disease, illness, injury or congenital anomaly requiring immediate medical attention during the Hospital stay in which the birth occurred; or
3. is not born of a mother with metabolic, endocrine or other disorders or predisposing factors which are known to cause problems in the care of the infant during the neonatal period.

MANAGED BENEFITS – Managed Care Guidelines

Subject to the terms and conditions of the Benefit Program, a Member is eligible for benefits for Covered Services for Medically Necessary Care when prescribed or ordered by a Physician and when in accordance with the provisions of this Managed Benefits Section.

Introduction

A Member's right to benefits for Covered Services provided under this Booklet is subject to certain policies or guidelines and limitations, including, but not limited to: Anthem Medical Policy; Prior Authorization; Concurrent Review; and Case Management. A description of each of these provisions are described in this section (Managed Benefits - Managed Care Guidelines) which explains its purpose; requirements; and effects on benefits.

Certain Services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem, on behalf of the Employer, may decide that a service treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

Failure to follow the Managed Care Guidelines for obtaining Covered Services will result in a reduction or denial of benefits.

NOTICE: Prior Authorization does NOT guarantee coverage for or the payment of the service or procedure reviewed. The Member should contact his/her Physician and/or Anthem BCBS to be sure that Prior Authorization has been obtained.

The Member should consult his/her Physician concerning courses of treatment and care. Notwithstanding any benefit determination, the Member and the Member's Physician must determine what care and/or treatment is received.

Questions regarding Managed Care Guidelines or to determine which services require Prior Authorization can be addressed by calling the telephone number on the back of the Member's Identification Card or refer to Anthem BCBS's website at: www.Anthem.com.

Selecting a Primary Care Physician / Provider (PCP)

We recommend you select a Primary Care Physician / Provider (PCP) from our network. PCPs include internists, family/general practitioners, pediatricians, geriatricians, and Advanced Practice Registered Nurse (APRN). Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

How to Access Primary and Specialty Care Services

How to obtain information about practitioners who participate in the organization:

Information about participating facilities or providers is available in the online network directory at www.anthem.com. You can find information such as a provider's location and professional qualifications. If you don't have access to the website or need help choosing a doctor, facility, or provider 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.

How to Access Primary and Specialty Care Services:

Your Benefit Program covers certain primary care services and specialty care services. To access Primary Care Services, simply visit any In-Network physician who is a general or family practitioner, internist, or pediatrician. Your Benefit Program covers care provided by any Network specialty care Provider you choose. Referrals are never needed to receive any specialty care Services.

To make an appointment call your physician's office:

- Tell them you are an Anthem BCBS Member
- Have your Member ID card handy. They may ask you for your group number, Member I.D. number, or cost-shares.
- 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.

Enhanced Personal Health Care Program

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

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

Your Responsibilities When Obtaining Health Care – Prior Authorization

Prior Authorization of certain services is required so that we can review the service to verify that it is Medically Necessary and that the treatment provided is the proper level of care.

Your Benefit Program includes the processes of Prior Authorization, Concurrent and Retrospective Reviews to determine when services should be covered by your Benefit Program. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of services that they are performed. Your Benefit Program requires that Covered Services be Medically Necessary for

benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior authorization criteria will be based on multiple sources including medical policy, and clinical guidelines. Anthem may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments which are more cost effective.

It is the Participating Provider's, other than BlueCard Provider's, responsibility to notify Anthem BCBS when Prior Authorization is required for certain services. Prior Authorization may be obtained by contacting Anthem BCBS at the telephone number located on the back of the Member's Identification Card.

The level of benefits for Covered Services, which are referred to in the Covered Services section of this Booklet, will depend on which options the Member chooses: either the In-Network Option; or the Out-of-Network Option. Please see the Schedule of Benefits for any Cost-Shares and Penalties for both options. Failure to follow the Managed Care guidelines for either option will result in either Penalties or denial of benefits.

Prior Authorization must be obtained prior to the initial treatment for an admission, service, procedure, or an extension of stay. With Prior Authorization, we guarantee payment for services that we approve in advance if the services are otherwise covered under the Booklet, the Coinsurance/Copayment/Deductible requirements are satisfied, and you are covered on the date you receive care. Benefits for Covered Services are subject to the terms, conditions and limitations of the Booklet. If Prior Authorization has been approved and needs to be reversed or rescinded, notice will be provided 3 business days prior to the schedule date of such admission. The Prior Authorization will indicate a period for approval. Any service not performed in the specified time frame will need to be re-authorized.

Non-Medically Necessary treatment or services for which the necessary Prior Authorization has not been obtained from Anthem BCBS will not be considered services eligible for reimbursement under this Booklet. The Member and Physician or Provider will receive written notification regarding the approval or denial of Prior Authorization.

Requesting Prior Authorization

Typically Network Providers, other than BlueCard Providers, know which services require Prior Authorization and will obtain any required Prior Authorization or request a predetermination when it is necessary. Your Primary Care Physician and other Participating Providers (non BlueCard) have been provided detailed information regarding Managed Care Guidelines procedures and are responsible for assuring that the requirements of Managed Care Guidelines are met. The ordering (or "requesting") Provider, facility or attending Physician will contact Us to request a Prior Authorization or predetermination review. 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 (non BlueCard): The Provider is responsible for Prior Authorization
- Services provided by a BlueCard or Non-Participating Provider: The Member is responsible for Prior Authorization

The Member is financially responsible for services and/or settings that are not covered under the Benefit Program based on an adverse determination of Medical Necessity 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.

Prior Authorization for Admissions

Prior Authorization for Hospital Admissions/Inpatient Facility Admissions, or Admission to a Partial Hospitalization or Day/Night Program.

When a Member is scheduled for an Admission to a Hospital, Skilled Nursing Facility, or Hospice it is the Participating Provider's (non BlueCard) responsibility to notify Anthem BCBS when Prior Authorization is required for certain services. If the Member decides to receive services Out-of-Network from a Non-Participating Physician; Non-Participating Hospital; Non-Participating Provider; or from a BlueCard Provider the Member must obtain Prior Authorization from Anthem BCBS. **Note: For guidelines regarding an Admission due to an Emergency Condition, please refer to the Medical Emergency Section.**

Elective Admissions

It is the Participating Provider's (non BlueCard) responsibility to notify Anthem BCBS when Prior Authorization is required. If the Member decides to receive services Out-of-Network from a Non-Participating Physician; Non-Participating Hospital; Non-Participating Provider; or from a BlueCard Provider the Member must obtain Prior Authorization from Anthem BCBS. The Participating Provider (non BlueCard) or Member (as applicable) must call Anthem BCBS for Prior Authorization at the number located on the back of the Member's Identification Card when the Admission is scheduled. This call must be made no later than one business day prior to the Elective Admission day.

- a. Once Anthem BCBS has been notified of the Admission, Anthem BCBS will contact the Member's Physician to obtain medical information relating to the Admission.
- b. During this process for Elective Admissions, the Admission day of the week will be checked. Friday or Saturday Admissions, or a Sunday Admission when Monday is a holiday will not be Authorized by Anthem BCBS unless the weekend Admission is determined to be Medically Necessary.
- c. For an Elective Admission, Anthem BCBS will either: Prior Authorize a number of Inpatient days or advise that Inpatient days cannot be Prior Authorized. The Member, Physician and Hospital will be notified in writing.

Emergency Services Admissions

This Benefit Program shall provide benefits for Emergency Services Admissions if the care is determined to be for an Emergency Condition. It is the Participating Provider's (non BlueCard) responsibility to notify Anthem BCBS within 2 business days of an Inpatient Admission due to an Emergency Condition. If the Member decides to receive services Out-of-Network from a Non-Participating Physician; Non-Participating Hospital; Non-Participating Provider; or from a BlueCard Provider; the Member must obtain Prior Authorization from Anthem BCBS within 2 business days of an Inpatient Admission due to an Emergency Condition. When the Member is admitted due to an Emergency Condition and Anthem BCBS is not notified within 2 business days, benefits for Covered Services shall only be provided if the Member's condition at the time of diagnosis, care or treatment is confirmed to have been an Emergency Condition.

Upon receiving proper notification of an Emergency Condition Admission, Anthem BCBS must authorize and manage continued Inpatient or Outpatient care related to the an Emergency Condition in order for such care to be covered under this Benefit Program.

Any follow-up diagnosis, care or treatment performed after the cessation of the Emergency Services must be provided by Participating Physicians in order for benefits to be considered as In-Network. Such Covered Services shall be subject to the Cost-Shares specified in the Schedule of Benefits for Participating Physicians, Participating Providers and Participating Hospitals.

Any follow-up diagnosis, care or treatment performed after the cessation of the Emergency Services and provided by Non-Participating Physicians shall be reimbursed based upon the Out-of-Network Option. Such Covered Services shall be subject to the Cost-Shares specified in the Schedule of Benefits for Out-of-Network services.

Concurrent Review

The availability of benefits for Inpatient Covered Services will be subject to Concurrent Review. Based on the results of the Concurrent Review, Anthem BCBS will determine that:

- There will be additional Inpatient days Prior Authorized ; or
- There will be a change in the services, supplies, treatment or setting; or
- There will be no additional Inpatient days Authorized as of a specific date.

If continued Hospitalization can no longer be authorized beyond a specific date, Anthem BCBS will assist the Member, Physician and Hospital to coordinate continued care, where appropriate.

No benefits will be provided under this Booklet or any other policy issued by Anthem BCBS for Inpatient Covered Services billed by the Hospital and the admitting Physician after the specific date indicated in the Anthem BCBS Authorization notice.

Decision and Notice Requirements

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

Request Category	Timeframe Requirement for Decision and Notification
Request for Medical Services	
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued / Concurrent Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued / Concurrent Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Continued / Concurrent Stay Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

Request for Mental Health and Substance Abuse Medical Services	
Urgent Pre-service Review – Levels of care include: Inpatient Services, Residential Treatment, Partial Hospitalization, or Intensive Outpatient Programs	24 hours from the receipt of the request
Non-Urgent Pre-service Review – Outpatient Services	15 calendar days from the receipt of the request
Urgent Continued / Concurrent Stay Review	24 hours from the receipt of the request
Non-Urgent Continued / Concurrent Stay Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

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 Benefit Program's Members.

Health Plan Individual Case Management

Our health plan individual 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.

In certain cases of severe or chronic illness or injury, Anthem BCBS, on behalf of the Employer, may provide benefits for alternate care that is not listed as a Covered Service. Anthem BCBS, on behalf of the Employer, may also extend Covered Services beyond the Benefit Maximums of this Benefit Program. Anthem BCBS, on behalf of

the Employer, will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem, and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

Penalties For Not Obtaining Prior Authorization

If the appropriate Prior Authorization is not obtained for Elective Admissions, benefits will be reduced, as shown on the Schedule of Benefits.

No benefits will be payable under the Benefit Program, for Physician Inpatient medical care visits or Hospital room and board charges if you or your Physician fail to obtain the Prior Authorization from Anthem BCBS as stated in this Managed Benefits – Managed Care Guidelines section, and Anthem BCBS determines the Admission is not Medically Necessary for an Inpatient setting. Further, if you elect to be admitted after a determination by Anthem BCBS that Inpatient days cannot be Prior Authorized there will be no payment for benefits.

A penalty will not be applied to you for medically necessary inpatient facility services from a Network or BlueCard provider.

Member Appeal Process

If Anthem BCBS denies, reduces or terminates benefits at any time during the review process, the Member, Member's representative, Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice or other Inpatient Facility or Physician may request an Appeal review. Please see the Grievance And External Review Process section for more details.

COVERED SERVICES – What’s Covered

This Section lists Covered Services and the benefits we pay, on behalf of the Employer. This Benefit Program shall provide benefits for the Covered Services described in this section when performed by a Participating Physician, Participating Provider, Participating Hospital, or Non-Participating Physician, Non-Participating Provider or Non-Participating Hospital, and subject to any applicable Cost-Share for Covered Services. Not complying with the guidelines outlined in the Managed Benefits Section of the Booklet may result in Penalties or the denial of benefits. Benefits are based on the setting in which Covered Services are received. Please see the Schedule of Benefits for any applicable Cost-Shares.

The following conditions apply to the description of Covered Services referenced in the Covered Services section:

- a. All Covered Services and Benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Booklet, including any attachments and riders.
- b. To receive maximum benefits for Covered Services, you must follow the terms of the Booklet, including, if applicable, receipt of care from your primary care physician, use of in-network providers, and obtaining any required Prior Authorization.
- c. Benefits for Covered Services are based on the Maximum Allowed Amount for such service.
- d. If you have an Out-of-Network benefit and use a non-Network Provider, you are responsible for the difference between the non-Network Provider’s charge and the Maximum Allowed Amount, in addition to any applicable Cost-Shares. Anthem BCBS cannot prohibit non-Network Providers from billing you for the difference in the non-Network Provider’s charge and the Maximum Allowed Amount. If you do not have an Out-of-Network benefit, your entire claim will be denied.
- e. Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of the Booklet.
- f. Anthem BCBS’s payment for Covered Services will be limited by any applicable Cost-Shares or benefit limits in the Booklet, including the Schedule of Benefits.
- g. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment.
- h. 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.

AMBULANCE SERVICES

This Booklet Covers:

Medically Necessary ambulance services are a Covered Service when 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.

And one or more of the following criteria are met:

- 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.

- For Medical transportation services provided through the Home Health Agency (in conjunction with the Home Health Care services), you are taken:
 - from a Hospital or Provider to Home after discharge;
 - to and from a Hospital or Provider for treatment; or
 - from Home to a Hospital or Provider, if readmission is necessary.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Ambulance services are subject to Medical Necessity reviews by us.

Benefits are available for Ambulance Services when the Member's condition at the time of the treatment is confirmed to have been a Medical Emergency and, in the course of such transport, care is provided as may be reasonably necessary to maintain the life of, or stabilize the condition of, the Member.

Emergency ground ambulance services do not require Precertification / Prior Authorization and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we selected, except in an emergency, no benefits will be available.

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

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 Benefit Program 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.

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.

Covered Services do not include:

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.

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.

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

- To a Doctor's office or clinic;
- To a morgue or funeral home;
- To Elective Hospital Admissions;
- In Wheelchair vans, ambulettes or medical cabs.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

CLINICAL TRIALS

This Booklet Covers:

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Benefit Program. 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 below, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services 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.
 - The Department of Veterans Affairs.
 - The Department of Defense.
 - 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 Benefit Program may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial, that would otherwise be covered by this Benefit Program.

All requests for clinical trials services, including services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

1. The Investigational item, device, or service; or
2. 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
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Routine Patient Care Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization, or other services provided to the Member during the course of treatment in Clinical Trial and Coverage for Routine Patient Care Costs incurred for off-label drug prescriptions. Hospitalization shall, for Routine Patient Care Costs, include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Out-of-Network Hospitalization will be rendered at no greater cost-share to the insured person than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

Routine Patient Care Costs shall not include:

1. The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;
2. The cost of a non-health care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the Clinical Trial;
3. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial;
4. Costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the Clinical Trial;

5. Costs that would not be covered under this Benefit Program for non-investigational treatments, including items excluded from coverage under the Benefit Program; and
6. Transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial, for the insured person or any family member or companion.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

DIABETES EQUIPMENT, EDUCATION, AND SUPPLIES
--

This Booklet Covers:

Your Plan included coverage for diabetic drugs, supplies and equipment.

Outpatient diabetes self-management training is covered if: prescribed by a licensed health care professional; and performed by: a certified; licensed; or registered health care professional trained in diabetes care; and operating within the scope of their license. Benefits are provided for: 10 hours of initial training; 4 hours of extra training because of changes in the person's condition; and 4 hours of training required by new developments in the treatment of diabetes.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

DIAGNOSTIC SERVICES

This Booklet Covers:

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

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed by us.

Non-Advanced Radiology - Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)

- Echocardiograms
- Breast Tomosynthesis
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Radiology - Diagnostic Imaging Services

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

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

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

Other Diagnostic Services

Benefits include, but are not limited to:

- Blood lead screenings and clinically indicated risk assessments.
- Sleep Studies - 1 complete Sleep Study per lifetime.
- Neuropsychological Testing - Psychological, neuropsychological, and neurobehavioral testing are covered as prescribed by State law.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Pre-certification / Prior Authorization may be needed for certain Diagnostic services, please see the Managed Care section for details.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

DURABLE MEDICAL EQUIPMENT AND MEDICAL DEVICES, ORTHOTICS, PROSTHETICS, AND MEDICAL AND SURGICAL SUPPLIES

This Booklet Covers:

Durable Medical Equipment and Medical Devices

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

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

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

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device.

Oxygen and equipment for its administration.

Hearing aids to aid or compensate for impaired human hearing.

Support Stockings

Orthotics

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

Prosthetics

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

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

- Artificial limbs and accessories.
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes).
- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs needed after cancer treatment.

- Cochlear implants.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose.

Benefits include wound-care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Doctor.

Covered Services do not include items often stocked in the home for general use (e.g. Band-Aids, thermometers, and petroleum jelly) and multi-purpose items that could be used for non-medical reasons (e.g. Tape, surgical gloves, batteries, battery chargers, and cleansing agents).

Blood and Blood Products

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

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

HOME CARE SERVICES

This Booklet Covers:

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

Covered Services include but are not limited to:

- Visits by a licensed health care professional, including nursing services by an R.N. or L.P.N., a therapist, or home health aide
- Medical / social services
- Diagnostic services. Please see “Diagnostic Services” earlier in this section.
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home). Please see “Therapy Services” later in this section.

- Medical supplies
- Durable medical equipment Please see “Durable medical equipment Services” earlier in this section.
- Hospice care provided in the home. Please see “Hospice Care” later in this section.

When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the “Mental Health and Substance Abuse Services” section below.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

While some services may be provided in your home, they will be covered as any other service of your Plan (e.g. Durable Medical Equipment will be covered under your “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” benefit).

Covered Services do not include:

Meals; personal comfort items; and housekeeping services.

Nursing services rendered in the home by a relative; even if that person is a registered nurse; or a licensed practical nurse.

Custodial Care, convalescent care, domiciliary care and rest home care are not home health services benefits under this Plan.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

HOSPICE SERVICES

This Booklet Covers:

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

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

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

Hospice Care provided in the home will be provided under you Home Care Services benefit and apply to the Home Care Services visit maximum.

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

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

HOSPITAL SERVICES

This Booklet Covers:

Inpatient Hospital Services:

Room and board for a semi-private Hospital room. If a private room is used, this Benefit Program shall only provide benefits for Covered Services up to the cost of the semi-private room rate, unless Anthem BCBS determines that a private room is Medically Necessary.

Following a mastectomy, benefits for Covered Services will be provided as follows:

At least 48 hours after a mastectomy or lymph node dissection unless otherwise agreed upon by the Member and Physician.

Inpatient and Outpatient Hospital services and supplies:

Use of an operating, delivery and treatment room, and equipment (including intensive care);

Prescribed drugs;

Administration of blood and blood processing;

Anesthesia, anesthesia supplies and services;

Medical and surgical dressing, supplies, casts and splints;

Diagnostic services;

Rehabilitative and restorative physical therapy and occupational therapy and speech therapy for treatment expected to result in the reasonable improvement of a Member's condition;

Radiation therapy;

Chemotherapy for treatment of cancer;

Laboratory tests;

X-ray or imaging studies;

Outpatient surgery;

Pre-admission testing;

Tests and studies required in connection with a scheduled Admission for surgery;

Services for hemodialysis or peritoneal dialysis for chronic renal disease, including equipment, training and medical supplies;

Services associated with accidental consumption or ingestion of a controlled drug or other substance.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

For Outpatient Surgery rendered in a licensed ambulatory surgical center (not located in a hospital setting) see the Other Provisions section.

The applicable Cost-Share is payable by a Member for every Admission, unless otherwise specified.

The benefits for a General Hospital with a participating agreement are unlimited.

Benefits for Non-Participating General Hospitals in and outside of Connecticut are limited to 30 days. Benefits are renewed when 30 consecutive days without Inpatient care have elapsed.

If a Member is admitted as an Inpatient a result of Outpatient surgery, the Member must notify Anthem BCBS within 2 business days of the Admission. Please refer to the Managed Benefits Section of this Booklet for information on how to notify us of your Admission.

Pre-Admission testing must be rendered to a Member as an Outpatient prior to the scheduled Admission and not repeated upon Admission for surgery. The Member will be responsible for the charges for Pre-Admission testing if the Member cancels or postpones the scheduled Admission.

Inpatient and Outpatient Hospital Dental Services - Anesthesia, nursing and related hospital charges for Inpatient dental services; outpatient hospital dental services; or one day dental services are covered if deemed Medically Necessary by the treating dentist or oral surgeon and the patient's primary care physician in accordance with Prior Authorization requirements and (1) the patient has been determined by a licensed dentist in conjunction with a licensed primary care physician to have a dental condition of sufficient complexity that it requires Inpatient services; outpatient hospital dental services; or one day dental services, or (2) the patient has a developmental disability, as determined by a licensed primary care physician, that places him or her at serious risk.

Covered Services do not include:

Private duty nursing services during an Inpatient Hospital Admission.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

HUMAN ORGAN AND TISSUE TRANSPLANT (BONE MARROW / STEM CELL / CORD BLOOD) SERVICES

This Booklet Covers:

Your Plan includes coverage for Medically Necessary Human Organ and Tissue Transplants. Cost-Shares for the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received.

Certain services (e.g., cornea and ventricular assist devices) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

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

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant.

Covered Transplant Procedure

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

Please note the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow / stem cells / cord blood is included in the Covered Transplant Procedure benefit regardless of the date of service.

In-Network Transplant Provider

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

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

To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details).

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. When you use an Out-of-Network Transplant Providers benefits will be covered at the Out-of-Network level.

When you chose an Out-of-Network Transplant Provider:

- If the Out-of-Network Transplant Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount.
- If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount.

Transplant Benefit Period

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

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

Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.

Prior Approval and Precertification

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

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Please see the “Managed Benefits – Managed Care Guidelines” section for how to obtain Precertification.

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

Donor Services

Live Donor Health Service

Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

Donor Searches

Your Plan includes one Human Leukocyte Antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per lifetime. The testing must be done at an accredited facility and at the time of testing you must sign a consent form authorizing the results of the testing to be used in the national Marrow Donor Program.

Unrelated donor searches from an authorized, licensed registry for bone marrow / stem cell / cord blood transplants for a Covered Transplant Procedure are covered by when approved through Precertification as described above. Donor search charges are limited to the 10 best matched donors, identified by an authorized registry.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 300 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to Us when claims are filed. Call Us for complete information.

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

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Covered Services do not include:

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

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

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

MATERNITY/FAMILY PLANNING SERVICES

This Booklet Covers:

Obstetrical care or pregnancy, delivery, prenatal and postpartum care. Care related to complications of pregnancy including surgery and interruptions of pregnancy.

Hospital Services including: room, board and Special Services, specified in the Hospital Services section of this Booklet.

Abortions and Miscarriages.

Infertility services

Infertility services are the Medically Necessary expenses of the diagnosis and treatment of infertility and include the following Prior Authorized services:

- Diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis.
- Services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).
- Covered Services also include Ovulation induction, Intrauterine insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), or ZIFT (zygote intra-fallopian transfer), and low tubal ovum transfer.

Although this Benefit Program offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment.

Infertility drugs will be provided for under the Prescription Drug Rider.

Prior Authorization is required. Please refer to the Managed Benefits Section of this Booklet for information on how to obtain Prior Authorization.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Birthcenter services are available only when the Provider has a participating agreement with Anthem BCBS.

Benefits for services for Members who have current symptoms or a diagnosed health problem may be billed in addition to the global fee (e.g., for additional ultrasounds during a high-risk pregnancy) under the “Diagnostic Services” benefit, and may be subject to additional Cost-shares, based on the setting in which Covered Services are received.

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

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

MEDICAL EMERGENCY

This Booklet Covers:

Ambulance services when the Member's condition at the time of the treatment is confirmed to have been a Medical Emergency.

Medical Emergency services provided at a Hospital's emergency room.

Medical Emergency services provided by a Physician.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

This Benefit Program shall only provide benefits for Medical Emergency services if the care is determined to be for a Medical Emergency. All Admissions resulting from a Medical Emergency must be approved by Anthem BCBS within 2 business days of the diagnosis, care or treatment of the Medical Emergency.

If the emergency requires that the Member be taken to the Hospital, this Benefit Program shall provide benefits for Covered Services for the Medical Emergency regardless of whether the Hospital is a Participating Hospital or Non-Participating Hospital.

If the emergency requires that the Member receive diagnosis, care or treatment from the first available Physician or Provider, this Benefit Program shall provide benefits for Covered Services for the Medical Emergency regardless of whether the Physician or Provider is a Participating Physician or Provider or Non-Participating Physician or Provider.

If the Medical Emergency requires a Member's Admission to a Non-Participating Hospital, this Benefit Program shall provide benefits for Covered Services as if the services were received at a Participating Hospital only through the day when the Member can be transferred to a Participating Hospital, as determined by Anthem BCBS. If the Member chooses to remain in the Non-Participating Hospital, the Member will be responsible for Non-Participating Hospital Cost-Shares in accordance with the Schedule of Benefits.

Claims for services rendered to the Member shall be subject to review by Anthem BCBS. Based on Anthem BCBS's review, the Member may be liable for Cost-Shares, or the full cost of all services rendered if Anthem BCBS determines that the services provided were not for a Medical Emergency. Medical Emergency Covered Services are limited to the treatment rendered during the initial visit only.

All services deemed by Anthem BCBS to be Medical Emergencies are eligible for benefits as if rendered by Participating Physicians, Participating Providers or Participating Hospitals as specified in the Schedule of Benefits and Benefit Chart.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

This Booklet Covers:

Covered Services include the following:

1. **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and stabilization services.
2. **Residential Treatment** in a licensed Residential Treatment Facility that offers individualized and intensive treatment, such as detoxification and stabilization services, and includes:
 - Observation and assessment by a physician weekly or more often,
 - Rehabilitation, therapy, and education.

Benefits for confinement in a Residential Treatment Facility shall be provided only in the following situations:

- the insured has a Medically Necessary, serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting; and
 - An individual Treatment Plan must be prescribed by a Physician with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.
3. **Outpatient Services** including office visits, therapy, treatment, evidence-based maternal, infant and early childhood home visitation services, detoxification and stabilization services, chemical maintenance treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs, Intensive In-Home Behavioral Health Services, Home-based therapeutic interventions for children, extended day treatments, and Observation beds in an acute hospital setting.

Outpatient care for mental illness includes services rendered in the following locations: a non-profit community mental health center, a non-profit licensed adult mental health center, a non-profit licensed adult psychiatric clinic operated by an accredited Hospital or in a Residential Treatment Facility when provided by or under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, licensed clinical Social Worker, licensed Marriage and Family Therapist or a I-Licensed or certified Alcohol and Drug Counselor; or appropriately licensed professional counselor or licensed Advanced Practice Registered nurse.

Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a Residential Treatment Facility under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, licensed clinical Social Worker, licensed Marriage and Family Therapist or a licensed or certified Alcohol and Drug Counselor or appropriately licensed professional counselor or licensed Advanced Practice Registered nurse.

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

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),

- Licensed marriage and family therapist (L.M.F.T.),
- Licensed or Certified Alcohol and Drug Counselor,
- Licensed professional counselor (L.P.C),
- Licensed Advanced Practice Registered nurse (A.P.R.N.), or
- Any agency licensed by the state to give these services, when we have to cover them by law.

The Facility must be licensed, registered and approved by the Joint Commission on Accreditation of Hospitals and meet specific rules set by us (Anthem BCBS).

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Precertification / Prior Authorization may be required. Please see the Managed Benefits section for how to get Precertification / Prior Authorization.

Covered Services do not include:

Mental health Care does not include:

- intellectual disabilities,
- specific learning disorders,
- motor disorders,
- communication disorders,
- caffeine-related disorders,
- relational problems, and
- other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders”.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

OFFICE VISITS, DOCTOR, AND SURGICAL SERVICES

This Booklet Covers:

Covered Services include:

- **Office Visits** for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.
- Allergy testing
- Inpatient Hospital/Inpatient Facility visits during a covered Admission
- Acute Psychiatric Care while an Inpatient at a Hospital or Inpatient Facility
- Inpatient consultations by other than the attending Physician - 2 per 30 day period

- Coverage for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for individuals eighteen years of age or younger if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association.
- **Home Visits** for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the “Home Care Services” benefit described earlier in this Booklet.

- **Surgical Procedures:**

If more than one surgical procedure is performed during the same operation, we will calculate the allowable charge for all the services combined by adding:

- The allowable charge for the service with the highest allowable charge; plus
- A reduced percentage of what the allowable charge would have been for each of the additional surgical services if these services had been performed alone. The amount of the reduced percentage will be on file with Anthem BCBS and available for inspection upon request.

- Surgical assistant services.

- **Reconstructive surgeries, procedures and services:**

In addition to the Exclusions and Limitations stated elsewhere in this Booklet, the following limitations apply:

Benefits are available for Medically Necessary reconstructive surgeries, procedures and services only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

1. Medically Necessary due to accidental injury; or
2. Medically 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 to restore or improve a bodily function; or
4. Medically Necessary to correct a birth defect for covered dependent children who have functional physical deficits due to a birth defect. Corrective surgery for children who do not have functional physical deficits due to a birth defect is not covered under any portion of this Booklet; or
5. Medically Necessary due to a mastectomy in accordance with the Women’s Health and Cancer Rights Act of 1998 (see below).

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

In addition to the above criteria, benefits are available for certain reconstructive surgery, procedures or 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 and
4. Port Wine Stain surgery.

- **Breast Reconstruction Surgery Benefits and the Women’s Health and Cancer Rights Act of 1998**

If you are receiving covered benefits for a mastectomy, you should know that the Women’s Health and Cancer Rights Act of 1998 provides for:

- reconstruction of the breast(s) on which a covered mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;

- prostheses and treatment of physical complications related to all stages of a covered mastectomy, including lymphedema (swelling). Prior authorization is not applicable to such prostheses.

The manner in which services are provided is between you and your physician. Coverage is subject to all of the terms and conditions stated in this Booklet, including any applicable Deductible, co-payment and coinsurance. You may be entitled to additional benefits as mandated by state law. Contact the Member Services Department at the number located on the back of your Identification Card for additional information.

- **Reconstructive Surgery**

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

- **Removal of breast implants**

For breast implants which were surgically implanted as a result of a mastectomy; benefits for Covered Services for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants; benefits for Covered Services for the Medically Necessary removal of any breast implant without regard to the reason for implantation, will be provided for at least \$1,000 per Member per Calendar Year.

- **Walk-In Doctor's Office**

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

- **Retail Health Clinic Care**

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

- **Online Visits**

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Physician using the internet by a webcam, chat or voice.

Online visits do not include:

- Reporting normal lab or other test results,
- requesting office visits,
- getting answers to Billing, insurance coverage or payment questions,
- asking for referrals to doctors outside the online care panel,
- Benefit Precertification / Prior Authorization,
- Physician to Physician consultation, or
- Doctor to Doctor discussions

For Mental Health and Substance Abuse Online Visits, see the "Mental Health and Substance Abuse Services" section.

- **Telehealth (Telemedicine):**

Telehealth covered Services that are appropriately provided by a Telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Agreement. Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail. If you have any questions about this coverage, or receive a bill please contact the Member Service Department at the number on the back of your Identification card.

- **Prescription Drugs Administered in the Office**

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Anthem BCBS will pay for the services of only one Physician in a given specialty if the surgery reasonably could be expected to be performed by one Physician.

Services of surgical assistants are payable as a surgery benefit based on approved surgical assistant procedures when a Hospital or ambulatory surgical facility does not provide surgical assistants through a residential or surgical assistant program.

Covered Services do not include:

Initial medical care for scheduled Admissions for surgery. This means the first non-surgical services rendered to a Member as an Inpatient by the attending Physician.

Separate charges for pre and post-operative care.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

ORAL SURGERY

This Booklet Covers:

The following are Covered Services, as determined by Anthem BCBS:

1. An initial visit for the prompt immediate repair of trauma, due to an accident or injury, to the jaw, natural teeth, cheeks, lips, tongue and/or the roof of the mouth. Benefits available for services provided during the initial visit, include but are not limited to the following:
 - Evaluation;
 - Radiology to evaluate extent of injury;
 - Treatment of the wound; tooth fracture or evulsion.

No additional benefits will be provided for any services rendered after the initial visit, including but not limited to: follow-up care, replacement of sound natural teeth, crowns, bridges, and prosthetic devices.

2. Oral surgical services for treatment of lesions, tumors and cysts on or in the mouth. Oral surgery services for treatment related to tumors of the oral cavity, treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw.
3. Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
4. Oral / surgical correction of accidental injuries.
5. Treatment of non-dental lesions, such as removal of tumors and biopsies.
6. Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this Benefit Program, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.

Covered Services do not include:

In the case of injury to the oral cavity, non-covered Prosthetic Devices include, but are not limited to, plates, bridges, dentures or caps/crowns.

Injury to teeth or soft tissue as a result of chewing or biting shall not be considered an accidental injury.

Removal of wisdom teeth.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

OTHER PROVISIONS

This Booklet Covers:

Outpatient Surgery in a licensed ambulatory surgical center (not located in a Hospital setting) (including colonoscopy) Note: See the Hospital Service section also for Outpatient Surgery rendered in a Hospital setting.

Outpatient self-management training for the treatment of diabetes including medical nutrition therapy.

Intravenous and oral antibiotic therapy for the treatment of Lyme Disease.

Medically Necessary Pain Management medications and procedures when ordered by a pain management specialist.

Birth to Three Program:

Services from birth to age three for early intervention Covered Services for a Member and his/her family members provided as part of an individualized family service plan.

Autism Spectrum Disorders:

Coverage shall be provided for the Medically Necessary diagnosis and treatment of Autism Spectrum Disorders based on an approved treatment plan. A treatment plan will be reviewed not more than once every six months unless the Member’s licensed Physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or as a result of changes in the Member’s treatment plan.

Covered Services include:

- Behavior Therapy rendered by an Autism Behavioral Therapy Provider and ordered by a licensed physician, psychologist or clinical social worker in accordance with a treatment plan developed by a licensed Physician, psychologist or licensed clinical social worker;
- Direct psychiatric or consultative services provided by a licensed psychiatrist;
- Direct psychiatric or consultative services provided by a licensed psychologist;
- Physical therapy provided by a licensed physical therapist;
- Speech therapy provided by a licensed speech and language pathologist; and
- Occupational therapy provided by a licensed occupational therapist.

As applicable, any visit limits for physical, speech and occupational therapy, will not apply to Autism Spectrum Disorder services. Please see the Schedule of Benefits for applicable Cost-Shares.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Coverage is provided for up to 30 days of intravenous antibiotic therapy, or 60 days of oral antibiotic therapy, or both, for the treatment of Lyme Disease. Further treatment is covered if recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

PRESCRIPTION DRUG

This Booklet Covers:

Prescription Drugs dispensed by a Pharmacy.

The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 34-day supply, except for insulin for which the maximum per Prescription Order is 4 vials.

Diabetic equipment, drugs and supplies.

Prescription drugs prescribed by a licensed Physician, advanced practice registered nurse, or licensed physician assistant for the treatment of symptoms and comorbidities of Autism Spectrum Disorders.

Notes:

If a Prescription Drug Rider has been added to this Booklet, the Maximum Allowed Amount for drug benefits will be paid under this Booklet after the Rider’s benefits have been exhausted.

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

Anthem BCBS has the right to deny benefits for any Prescription Drug that in its judgment is not prescribed or dispensed in a manner consistent with normal medical practice.

Covered Services do not include:

Prescription Drugs which are not required for the treatment or prevention of an illness or injury.

Antibacterial soaps, detergents, shampoos, toothpaste/gels, and mouthwashes/rinses.

Parenteral nutritional products.

Prescription Drugs dispensed in a Hospital, clinic, Skilled Nursing Facility, nursing home or other institution.

Prescription Drugs which are used in connection with male or female sexual dysfunctions or inadequacies, or erectile dysfunctions or inadequacies, regardless of origin or cause.

A contraceptive or contraceptive device that has not been approved by the Federal Food and Drug Administration, and is not prescribed by a licensed Physician.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER
--

This Booklet Covers:

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

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),

- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated (Any step therapy regimen shall be implemented consistent with applicable law),
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of our decision to both you and your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which Drugs are covered under this section and if any drug edits apply.

Please refer to the section “Getting Approval for Benefits” for more details.

If precertification is denied you have the right to file a Grievance as outlined in the “Grievance Review Procedures” section of this Booklet.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

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

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

PREVENTIVE CARE SERVICES

This Booklet Covers:

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the “Diagnostic Services” benefit instead of this benefit, if the coverage does not fall within the state or ACA recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - Breast cancer,
 - Cervical cancer,
 - Colorectal cancer,
 - High blood pressure,
 - Type 2 Diabetes Mellitus,
 - Cholesterol,
 - Child and adult obesity,
 - Routine vision screening,
 - Routine hearing screening.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - Women’s contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered as a Preventive care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the Prescription Drug Rider.
 - Breastfeeding support, supplies, and counseling: Benefits for breast pumps are limited to one pump per pregnancy.
 - Screenings and/or counseling, where applicable, including but not limited to: Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
 - Counseling
 - Prescription Drugs
 - Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including, but not limited to:
 - Aspirin
 - Folic acid supplement
 - Vitamin D supplement
 - Bowel preparations

Please note that certain age and gender and quantity limitations apply.

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

Notes:

Preventive services are only covered in full when provided by an In-Network Provider.

Cost-Shares may apply to services provided during the same visit as preventive services. For example, if a preventive service is provide during an office visit wherein that service is not the primary purpose of the visit, the cost-sharing amount that would otherwise apply to the office visit will still apply.

Covered Services do not include:

Exams in any way related to school or employment.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

PRIVATE DUTY NURSING SERVICES

This Booklet Covers:

Private Duty Nursing Services.

A Registered Nurse (RN) or a Licensed Practical Nurse (LPN) defines Private Duty Nursing (PDN) as the provision of medically necessary, complex skilled nursing care in the home.

The purpose of private duty nursing is to assess, monitor and provide skilled nursing care in the home on an hourly basis; to assist in the transition of care from a more acute setting to home; and to teach competent caregivers the assumption of this care when the condition of the member is stabilized. The length and duration of private duty nursing services are intermittent and temporary in nature and not intended to be provided on a permanent, ongoing basis.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares and the Important Notes about Your Benefits and Cost-Shares section to determine if any maximums apply.

Covered Services do not include:

Private duty nursing care services for the convenience of the Member or while the Member is an Inpatient in a Hospital or Skilled Nursing Facility.

Care primarily to provide room and board (with or without routine nursing care), training in personal hygiene, and other forms of self-care.

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

SKILLED NURSING FACILITIES

This Booklet Covers:

Skilled nursing care;
Rehabilitative and related services; and
Semiprivate room and board.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.
Prior Authorization is required. Please see the Managed Benefits Section of this Booklet for how to get Prior Authorization.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.
Room and board charges exceeding the Skilled Nursing Facility's most common semi-private rate shall be excluded.

SPECIALIZED FORMULA AND MODIFIED FOODS

This Booklet Covers:

Specialized Formula is a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration.

Coverage for Specialized Formula is intended for use of dietary management of specific disease when under the medical direction and supervision of a doctor, when such specialized formulas are medically necessary for the treatment of that disease or condition.

Benefits also include Amino acid modified preparations; and low protein modified food products for the treatment of inherited metabolic diseases and cystic fibrosis.

All services must be authorized by us as outlined in the "Managed Care" section.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

THERAPY SERVICES

This Booklet Covers:

Outpatient Rehabilitation

Outpatient physical, occupational, speech and chiropractic therapy;

Outpatient cardiac rehabilitation therapy;

Other Therapy Services

Radiation therapy;

Chemotherapy for the treatment of cancer;

Electroshock Therapy;

Kidney Dialysis in a Hospital or free-standing dialysis center;

Infusion Therapy – Benefit will be provided for Outpatient Hospital; Physician office, ambulatory infusion suite or home Infusion Therapy regimens under the following conditions:

1. A plan of care for such services is prescribed in writing by a Physician (M.D.);
2. The plan of care is reviewed and recertified by the Physician (M.D.);
3. Infusion Therapy is limited to:
 - a. Chemotherapy (including gamma globulin);
 - b. intravenous antibiotic therapy;
 - c. total parenteral nutrition;
 - d. enteral therapy when nutrients are only available by a Physician's prescription;
 - e. intravenous pain management;
4. Covered Services will include supplies, solutions, and pharmaceuticals and nursing.

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Any Cost-Shares or Maximum visits listed in the Schedule of Benefits for Outpatient Physical, Occupational, and Speech Therapy services apply regardless of place of service.

Speech therapy is a Covered Service when prescribed by a Physician (M.D.) and provided by a licensed speech pathologist.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

URGENT CARE SERVICES

This Booklet Covers:

Urgent Care services received at a designated Urgent Care Facility.

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

Benefits for urgent care include:

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

Notes:

Please see the Schedule of Benefits for any applicable Cost-Shares.

Urgent Care Services at an Urgent Care Facility are a lower level of complexity than emergency care in a hospital setting.

Urgent Care services will be covered only if your signs and symptoms at the time of treatment are such that Urgent Care services are Medically Necessary as determined by Anthem BCBS.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Booklet for other services not covered under this Benefit Program.

EXCLUSIONS AND LIMITATIONS – What’s Not Covered

In addition to the other limitations, conditions and exclusions set forth elsewhere in this Booklet, no benefits will be provided for expenses related to the services, supplies, conditions or situations described in this section. These items and services are not covered even if you receive them from your Provider or according to your Provider’s Referral.

Please remember, this Benefit Program does not cover any service or supply not specifically listed as a Covered Service in this Booklet. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem BCBS is the final authority for determining if services or supplies are Medically Necessary.

The listed exclusions below are in addition to those set forth elsewhere in the Booklet.

The following services are not Covered Services under this Benefit Program, except when approved by Anthem BCBS as part of Case Management.

1. **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, Participation in a Riot or civil disobedience.
2. **Acupuncture:** Services for Acupuncture
3. **Administrative Charges:**
 - Charges to complete claim forms,
 - Charges to get medical records or reports,
 - Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
4. **Applied Behavioral Treatment:** Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the Covered Services - “What’s Covered” section unless otherwise required by law.
5. **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan. Any person getting services before this Benefit Program is effective or after it has terminated will be solely responsible for payment of such services.
6. **Benefits for services which are not:**
 - specifically described in the Booklet
 - rendered or ordered by a Physician
 - within the scope of the Physician’s, Provider’s or Hospital’s licensure; and
 - Medically Necessary Care for the proper diagnosis and treatment of the Member.
7. **Certain Providers:** Certain Providers Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
8. **Charges Over the Maximum Allowed Amount:** Charges over the Maximum Allowed Amount for Covered Services.

9. **Charges Not Supported by Medical Records:** Charges for services not described in your medical records.
10. **Clinically-Equivalent Alternatives:** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most patients, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

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

11. **Complications of / or Services Related to Non-Covered Services:** Services, supplies, or treatment related to or for problems directly related to a service that is not covered by this Benefit Program. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
12. **Compound Drugs:** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA’s Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
13. **Cosmetic Services:** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin, or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy.

14. **Court Ordered Services:** Court ordered testing or care, including alcohol or drug abuse courses, unless Medically Necessary.
15. **Crime:** Treatment of an injury or illness that results from a crime you committed, or tried to commit which resulted in your conviction of a felony. This Exclusion does not apply if: during the time of the crime or attempted crime you had an elevated blood alcohol content or were under the influence of an intoxicating liquor or any drug or both; or your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
16. **Cryopreservation:** Charges associated with the Cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
17. **Custodial Care:** Custodial Care, unless otherwise required by Federal or State law, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
18. **Delivery Charges:** Charges for delivery of Prescription Drugs
19. **Dental Treatment** Excluded treatment includes but is not limited to preventive care and fluoride treatments, dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:
- Removing, restoring, or replacing teeth;
 - Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
 - Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

20. **Drugs Contrary to Approved Medical and Professional Standards** Drug given to you or prescribed in a way that is against approved medical and professional standards of practice.

21. **Drugs Over Quantity or Age Limits:** Drugs which are over any age quantity or limits set by the Benefit Program or us.
22. **Drugs Over the Quantity Prescribed or Refills After One Year:** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
23. **Drugs Prescribed by Providers Lacking Qualifications/ Registrations/Certifications:** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by us.
24. **Drugs That Do Not Need a Prescription:** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
25. **Educational Services:** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
26. **Emergency Room Services for non-Emergency Care:** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician / Provider.
27. **Experimental or Investigational Services:** Treatment; procedure; facility; equipment; drugs; devices; or supplies. Any services associated with; or as follow-up to any of the above is not a Covered Service.
28. **Eyeglasses and Contact Lenses:** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet.
29. **Family Members:** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
30. **Foot Care:** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
 - Cleaning and soaking the feet.
 - Applying skin creams to care for skin tone.
 - Services performed in conjunction with the fitting of supportive or comfort devices for the foot
 - Other services that are given when there is not an illness, injury or symptom involving the foot.
31. **Foot Orthotics:** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
32. **Free Care Services:** Services you would not have to pay for if you didn't have this Benefit Program. This includes, but is not limited to government programs, services during a jail or prison sentence and services from free clinics.
33. **Gene Therapy:** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
34. **Infertility Treatment:** Infertility procedures not specified in this Booklet.
35. **Inpatient private duty nursing.**
36. **Lost or Stolen Drugs:** Refills of lost or stolen Drugs.
37. **Maintenance Therapy (Maintenance Care):** Rehabilitative treatment given when no further gains are clear or likely to occur, unless required under state or federal law. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
38. **Medical Equipment, Devices, and Supplies:**
 - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Non-Medically Necessary enhancements to standard equipment and devices.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

39. **Missed or Cancelled Appointments:** Charges for missed or cancelled appointments.

40. **Non-Medically Necessary Services:** Unless otherwise required by Federal or State law, services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

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

42. **Off label use:** Off label use, unless we must cover it by law or if we approve it.

43. **Onychomycosis Drugs:** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.

44. **Over-the-Counter Items:** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend Drugs when any version or strength becomes available over the counter, unless otherwise required by law, or is otherwise determined by us to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to us, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care” benefit under federal law with a Prescription.

45. **Personal Care and Convenience:**

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

46. **Residential accommodations:** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary 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.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
 - Wilderness camps.
47. **Routine Physicals / Services required by third parties:** Physical exams required for travel, enrollment in any insurance program, as a condition of employment, for licensing, school registration, sports programs, camps, or for other purposes, which are not required by law under the “Preventive Care” benefit.
 48. **Sex Change:** Evaluation, treatment, and procedures related to and performance of sex-change operations including follow-up treatment, care and counseling, unless the Member has been diagnosed with gender dysphoria and all Medically Necessary criteria are met as determined by Anthem BCBS in accordance with generally accepted medical standards.
 49. **Surrogate Mother Services:** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
 50. **Temporomandibular Joint Treatment (TMJ)** Services or supplies for the treatment of temporomandibular and craniomandibular disorders. This includes removable appliances for TMJ repositioning and related surgery, medical care, diagnostic services, fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).
 51. **Travel Costs:** Mileage, lodging, meals, and other Member-related travel costs except as described in this Benefit Program.
 52. **Vision Services:** Vision services not described as Covered Services in this Booklet.
 53. Benefits may be reduced or denied subject to the Managed Benefits – Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not apply toward the Out-of-Pocket Limit shown in the Schedule of Benefits.
 54. Any reduction in benefits, including but not limited to Penalties, imposed by another Plan, which are similar to those stated in the Managed Benefits – Managed Care Guidelines, are not reimbursable as a Covered Service.
 55. Care for conditions which are required by State or Local law to be treated in a public facility.
 56. Services and care in a Veteran’s Hospital or any Federal Hospital, except as may be otherwise required by law.
 57. Services covered in whole or in part by public or private grants.
 58. Simplified or self-administered tests and multiphasic screening.
 59. Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.
 60. Charges for the Member’s room and board when the Member has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.
 61. Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
 62. Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
 63. Services which the Member or Anthem BCBS is not legally required to pay.
 64. Wigs, except as noted in the Covered Services Section.
 65. Inpatient services which can be properly rendered as Outpatient services.

66. Disease contracted or injuries resulting from war.
67. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
68. Supervisory care by a Physician for a Member who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.
69. Certain pulmonary function tests which in the opinion of Anthem BCBS do not meet the definition of a covered diagnostic laboratory test.
70. Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.
71. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
72. Radiation therapy as a treatment for acne vulgaris.
73. Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Benefit Program pays benefits as a result of injuries or illnesses You sustained and You have a right to a Recovery or have received a Recovery from any source on account of Your injuries or illnesses. Your acceptance of benefits under such circumstances constitutes Your acknowledgment of the Benefit Program's right of reimbursement for such benefits and Your consent to reimburse the Benefit Program from Your Recovery. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by verdict, judgment, award, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Benefit Program has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Benefit Program has the right to take whatever legal action it sees fit against any person, party or entity who is liable for Your illnesses or injuries, including making a claim in Your name or in the Benefit Program's name, to recover the benefits paid under the Benefit Program. The Benefit Program is not obligated in any way to pursue its subrogation right independently or on Your behalf, but may choose to pursue its rights at its sole discretion. The Benefit Program may assert this right independently of You.
- The Benefit Program has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Benefit Program to exercise the Benefit Program's subrogation rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Benefit Program to exercise its subrogation rights, the Benefit Program shall be entitled to deduct the amount the Benefit Program paid from any future benefits under the Benefit Program.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Benefit Program's subrogation claim and any claim held by You, the Benefit Program's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Benefit Program is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Benefit Program.
- Anthem BCBS has the right to pursue and enforce the Benefit Program's rights under this provision.

Reimbursement

If You obtain a Recovery and the Benefit Program has not been repaid for the benefits the Benefit Program paid on Your behalf, the Benefit Program shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must promptly reimburse the Benefit Program from any Recovery to the extent of benefits the Benefit Program paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Benefit Program shall have a right of full recovery, in first priority, against any Recovery. Further, the Benefit Program's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Benefit Program the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Benefit Program in the amount of benefits paid by the Benefit Program immediately upon receipt of the Recovery by You or Your legal representative. You and Your legal representative acknowledge that the Benefit Program's lien in the amount of benefits paid by the Benefit Program applies to the Recovery and is a Benefit Program asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Benefit Program has been repaid in accordance with these provisions.
- You must reimburse the Benefit Program, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to reimburse the Benefit Program.
- If You fail to repay the Benefit Program, the Benefit Program shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Benefit Program has paid or the amount of Your Recovery whichever is less, from any future benefit under the Benefit Program if:
 1. The amount the Benefit Program paid on Your behalf is not repaid or otherwise recovered by the Benefit Program; or
 2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement to the Benefit Program, the Benefit Program shall be entitled to deduct the amount of the Benefit Program's lien from any future benefit under the Benefit Program.
- The Benefit Program shall also be entitled to recover any unsatisfied portion of the amount the Benefit Program has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Benefit Program has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Benefit Program will not have any obligation to pay the Provider or reimburse You.
- The Benefit Program is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.
- Anthem BCBS has the right to pursue and enforce the Benefit Program's rights under this provision.

Your Duties

- You must promptly notify the Benefit Program in writing whenever benefits are paid under the Benefit Program that arise out of injuries, illnesses, or other conditions that provides or may provide the Benefit Program subrogation or reimbursement rights, including how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Benefit Program and/or Anthem BCBS.
- You must cooperate fully with the Benefit Program and Anthem BCBS in the investigation, settlement and protection of the Benefit Program's rights. Cooperation means providing the Benefit Program with any relevant information as requested, signing and delivering such documents as required by the Benefit Program and/or Anthem BCBS to secure the Benefit Program's lien or subrogation rights, and obtaining the consent of the Benefit Program and/or Anthem BCBS before releasing any third party from liability for payment of Your medical expenses.
- You must send the Benefit Program and/or Anthem BCBS copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Benefit Program and/or Anthem BCBS if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Benefit Program and/or Anthem BCBS if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.
- You must not do anything to interfere with or prejudice the Benefit Program's rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Benefit Program to exercise its subrogation or reimbursement rights, the Benefit Program shall be entitled to deduct the amount the Benefit Program paid from any future benefits under the Benefit Program.

Anthem BCBS has complete discretion to interpret the terms of the Subrogation and Reimbursement provision of this Benefit Program in its entirety and reserves the right to make changes as it deems necessary.

If the Member is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the Member's relatives, heirs, and/or assignees obtain any Recovery because of injuries sustained by the Member that Recovery shall be subject to this provision.

Anthem BCBS has the right to conduct recovery actions to enforce this provision on behalf of the Benefit Program and may seek legal action against You to recover benefits related to Your injuries or illnesses.

The Benefit Program is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Benefit Program shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by You to the contrary. The Benefit Program shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

WORKERS' COMPENSATION

To the extent permissible by law no benefits shall be provided for Covered Services paid, payable or eligible for coverage under any Workers' Compensation Law, employer's liability or occupational disease law, denied under a managed Workers' Compensation program as Out-of-Network services or which, by law, were rendered without expense to the Member.

The Benefit Program shall be entitled to the following:

- To charge the entity obligated under such law for the dollar value of those benefits to which the Member is entitled.
- To charge the Member for such dollar value, to the extent that the Member has been paid for the Covered Services.
- To reduce any sum owing to the Member by the amount that the Member has received payment.
- To place a lien on any sum owing to the Member for the amount the Benefit Program has paid for Covered Services rendered to the Member, in the event that there is a disputed and/or controverted claim between the Member's Employer and the designated Workers' Compensation insurer as to whether or not the Member is entitled to receive Workers' Compensation benefits payments.
- To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.
- If a Member is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines in the Managed Benefits Section in order for this Benefit Program to continue to provide benefits for Covered Services when the Workers' Compensation benefits are exhausted.

Anthem BCBS has the right to enforce the Benefit Program's rights under this provision.

AUTOMOBILE INSURANCE

To the extent permissible by law, benefits shall not be provided by this Benefit Program for Covered Services paid, payable or required to be provided as basic reparations benefits under any no-fault or other automobile insurance policy.

The Benefit Program shall be entitled:

To charge the insurer obligated under such law for the dollar value of those benefits to which a Member is entitled;

- To charge the Member for such dollar value, to the extent that the Member has received payment from any and all sources, including but not limited to, first party payment.
- To reduce any sum owing to the Member by the amount that the Member has received payment from any and all sources, including but not limited to, first party payment.
- Benefits shall be subject to Coordination of Benefits as described in the Coordination of Benefits Section of this Booklet, for Covered Services a Member receives under an automobile insurance policy which provides benefits without regard to fault.
- A Member who fails to secure no-fault insurance required by applicable law shall be deemed to be his or her own insurer and the Benefit Program shall reduce his or her benefits for Covered Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.
- If a Member is entitled to benefits under a no-fault or other automobile insurance policy, benefits for Covered Services will only be provided when a Member follows all of the guidelines stated in the Managed Benefits Section of the Booklet. It is necessary to follow all the guidelines in the Managed Benefits Section in order the Benefit Program to continue to provide benefits for Covered Services when the no-fault or other automobile insurance policy benefits are exhausted.

Anthem BCBS has the right to enforce the Benefit Program's rights under this provision.

COORDINATION OF BENEFITS

All benefits provided under this Benefit Program are subject to the Coordination of Benefits provision as described in this Section.

Applicability

The Coordination of Benefits (COB) provision applies to this Benefit Program when a Member has health care coverage under more than one Plan as defined below.

If the Member is covered by this Benefit Program and another Plan, the Order of Benefit Determination Rules in this Section shall decide which Plan is the Primary Plan. The benefits of this Plan:

- a. Shall not be reduced when under the Order of Benefit Determination Rules this Benefit Program is the Primary Plan; but
- b. May be reduced or the reasonable cash value of any Covered Service provided under this Benefit Program may be recovered from the Primary Plan when under the Order of Benefit Determination Rules another Plan is the Primary Plan. The above reduction is described in the Effect Of This Benefit Program On The Benefits subsection;
- c. Penalties imposed on a Member by the primary carrier are not subject to COB;
- d. The Member must submit the explanation of benefits from the Primary Plan to Anthem BCBS within two years of the date of service in order to be eligible for payment under this Coordination of Benefits Section.

Definitions

In addition to the defined terms listed in the Definitions section of this Benefit Program, the following also apply to this Coordination of Benefits Section.

ALLOWABLE EXPENSE:

The term Allowable Expense means a Medically Necessary Allowable Expense, for an item of expense for health care, when the item of expense, including any Cost-Share amounts, is covered at least in part by one or more Plans covering the Member for whom the claim is made. When this Benefit Program provides Covered Services, the reasonable cash value of each Covered Service is the Allowable Expense and is a benefit paid.

Allowable Expense does not include coverage for:

- Dental Care, Vision care, Prescription Drugs, or hearing aid programs.
- The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary.
- The amount that is subject to the Primary high-Deductible health plan's Deductible, if We have been advised by you that all Plans covering you are high-Deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

CLAIM DETERMINATION PERIOD:

The term Claim Determination Period means a Calendar Year. However, it does not include any part of a Calendar Year during which a person has no coverage under this Benefit Program, or any part of a Calendar Year before the date this COB provision or a similar provision takes effect.

PLAN:

For the purpose of this Section, the term Plan means any of the following which provides benefits or services for, or because of, medical care or treatment:

- a. Group health insurance, group-type coverage, whether fully insured or self-insured, or any other contract or arrangement where a health benefit is provided. This includes prepayment, staff or group practice association health maintenance organization coverage.
- b. Coverage under a governmental Plan or required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, or the United States Social Security Act as amended from time to time). It also does not include any Plan when, by law, its benefits are more than those of any private insurance program or other non-governmental program.
- c. Medical benefits coverage of no-fault and traditional automobile fault contracts, as provided in this Section.

Each contract or other arrangement for coverage under (a), (b) or (c) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

PRIMARY PLAN:

The term Primary Plan means a Plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either (a) or (b) below is true:

- a. The Plan either has no Order of Benefit Determination rules or it has rules which differ from those stated in this Section; or
- b. All Plans which cover the person use the Order of Benefit Determination rules as shown in this Section and under those rules the Plan decides its benefits first. There may be more than one Primary Plan (for example: two Plans which have no Order of Benefit Determination rules).

When this Benefit Program is the Primary Plan, Covered Services are provided or covered without considering the other Plan’s benefits.

SECONDARY PLAN:

The term Secondary Plan means a Plan which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the Order of Benefit Determination rules of this Section decide the order in which the benefits are determined in relation to each other. The benefits of the Secondary Plan may take into account the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this Section, has its benefits determined before those of the Secondary Plan.

When this Benefit Program is the Secondary Plan, benefits for Covered Services under the Benefit Program may be reduced and the Benefit Program, or Anthem BCBS on its behalf, may recover from the Primary Plan, the Provider of Covered Services, or the Member, the reasonable cash value of the Covered Services provided by this Benefit Program.

Order of Benefit Determination Rules

1. General Rule

When a Member receives Covered Services by or through this Benefit Program or is otherwise entitled to claim benefits under this Benefit Program and has followed all Anthem BCBS guidelines and procedures, including Prior Authorization requirements as specified in this Benefit Program, and the Covered Services are a basis for a claim under another Plan, this Benefit Program is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- a. The other Plan has rules coordinating its benefits with those described in the Booklet; and

- b. Both the other Plan's rules and this Benefit Program's coordination rules, as described below, require that this Benefit Program's benefits be determined before those of the other Plan.

2. Coordination Rules

Anthem BCBS decides its order of benefits using the following rules:

a. Other than a Dependent

The benefits of the Plan which covers the person as a Subscriber (that is, other than as a Dependent) are primary to those of the Plan which covers the person as a Dependent;

b. Dependent Child/Parents Not Separated or Divorced

When this Benefit Program and another Plan cover the same child as a Dependent of different persons, called "parents" the Plan of the parent whose birthday falls earlier in a year is primary to the Plan of the parent whose birthday falls later in that year, but if both parents have the same birthday, the Plan which covered a parent longer is primary. Only the month and day of the birthday are considered.

c. Dependent Child/Separated or Divorced Parents

In the case of a Member for whom claim is made as a Dependent child:

- i. When the parents are separated or divorced and the parent with legal custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with legal custody of the child shall be determined before the benefits of a Plan which covers the child as a Dependent of the parent without legal custody;
- ii. When the parents are divorced and the parent with legal custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent; and

The benefit of a Plan which covers that child as a Dependent of the step-parent shall be determined before the benefits of a Plan which covers that child as a Dependent of the parent without legal custody.

If the terms of a court order state that one of the parents is financially responsible for the health care expenses of the child, then the Plan which covers the child as a Dependent of the financially responsible parent shall be determined before the benefits of any other Plan which covers the child as a Dependent child. The provisions of this Subsection do not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payor has that actual knowledge.

d. Active/Inactive Employee

A Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) is primary to a Plan which covers that person as a laid-off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (d) is ignored.

e. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the Plan which covered you longer is primary to the Plan which covered that person for the shorter time.

f. Medicare

If a Member is eligible for Medicare and still covered under this Benefit Program, Anthem BCBS will administer the benefits of this Benefit Program, except as required by law. However, these benefits will be reduced to an amount which, when added to the benefits received pursuant to Medicare, may equal, but not be more than the actual charges for services covered in whole or in part by either this Benefit Program or Parts A, B and D of Medicare.

(Note: Certain services may not require Prior Authorization when it is determined that Anthem BCBS is the Secondary Plan. Contact Member Services before any services are rendered to determine if such services require Prior Authorization. In the event that a later determination finds that Anthem BCBS is the Primary Plan, any services that were obtained without Prior Authorization while Anthem BCBS was administering benefits as a Secondary Plan will not require Prior Authorization as would be required under a Primary Plan.)

Effect Of This Benefit Program On The Benefits

1. This Subsection applies when, in accordance with the Order of Benefit Determination Rules, this Benefit Program is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Benefit Program may be reduced under this Subsection. Such other Plan or Plans are referred to as “the other Plans.”
2. Reduction in this Benefit Program’s benefits. When the Benefit Program is the Secondary Plan, Anthem BCBS will provide benefits under the Benefit Program so that the sum of the reasonable cash value of any Covered Service provided by the Benefit Program and the benefits payable under the other Plans shall not total more than the Allowable Expense. Benefits will be provided by the Secondary Plan at the lesser of: the amount that would have been paid had it been the Primary Plan or the balance of the bill. Anthem BCBS shall never pay more than it would have paid as the Primary Plan.

If another Plan provides that its benefits are “excess” or “always secondary” (known as the non-complying Plan) and if this Benefit Program is determined to be secondary under this Benefit Program’s COB provisions, the amount of benefits payable under this Benefit Program shall be determined on the basis of this Benefit Program being secondary. If the non-complying Plan does not provide the information needed by this Plan to determine its benefits within a reasonable time after it is requested to do so, this Plan shall assume that the benefits of the non-complying Plan are identical to its own, and shall pay its benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

Right To Receive And Release Needed Information

Certain information is needed to apply these COB rules. Anthem BCBS has the right to decide which information it needs. By enrolling in the Benefit Program the Member consents to the release of information needed to apply the COB rules. Any Member claiming benefits under this Benefit Program must furnish information to Anthem BCBS which Anthem BCBS determines is necessary for the coordination of benefits.

Facility Of Payment

A payment made or a service provided under another Plan may include an amount which should have been paid or provided under this Benefit Program. If it does, Anthem BCBS may pay that amount to the organization which made that payment. Such amount shall then be considered as though it were a benefit paid under this Benefit Program.

Right Of Recovery

If the amount of the payments made by the Benefit Program is more than it should have paid under this COB provision, or if it has provided services which should have been paid by the Primary Plan, the Benefit Program may recover the excess or the reasonable cash value of the Covered Services, as applicable, from one or more of the persons it has paid or for whom it has paid, insurance companies, or other organizations.

The right of the Benefit Program to recover from a Member shall be limited to the Allowable Expense that the Member has received from another Plan. Acceptance of Covered Services will constitute consent by the Member to the Benefit Program's right of recovery. The Member agrees to take all further action to execute and deliver such documents as may be required and do whatever else is necessary to secure the Benefit Program's rights to recover excess payments. The Member's failure to comply may result in a withdrawal of benefits already provided or a denial of benefits requested.

Anthem BCBS has the right to enforce the Benefit Program's rights under this provision.

CLAIMS PROVISIONS

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

Anthem BCBS reserves the right to review any submitted claims for services and has complete discretion to interpret and apply the terms of the Benefit Program and to determine which services are eligible for payment.

Maximum Allowed Amount (MAA)

General

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

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

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

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

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

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

Provider Network Status

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

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-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 Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

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

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

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

For Covered Services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

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

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Member Services can

assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

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

Member Cost-Share

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

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

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

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

We and/or our designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under this Benefit Booklet and which positively impact the cost effectiveness of Covered Services. These amounts are retained by us. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

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

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

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

- The Out-of-Network anesthesiologist’s charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. Provided the Deductible has been met, your total out-of-pocket responsibility would be \$190 (20% Coinsurance responsibility).*
- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out-of-pocket responsibility would be \$300.*

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

Authorized Services

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

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

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

- *Your Benefit Program has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.*
- *Because we have authorized the In-Network cost-share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$175 of the \$200 Maximum Allowed Amount.*
- *Because the Out-of-Network Provider's charge for this service is \$500, you may receive a bill from the Out-of-Network Provider for the difference between the \$500 charge and the Maximum Allowed Amount of \$200. Combined with your In-Network Copayment of \$25, your total out-of-pocket expense would be \$325.*

Claim Procedures

The Claims Procedures outlined in the Booklet describe the procedures that Anthem BCBS will use to decide claims for various benefits.

Appeals procedures for all types of benefits are described in this Booklet. Please see the Grievance And External Review Process for appeals information.

Contact Anthem BCBS for more information about how to file a claim for benefits or appeal a claim denial. The Member must exhaust all of the appeals procedures available under this Benefit Program that are applicable to the benefit you are seeking prior to bringing legal action in court.

Claims Procedure

The following claims procedures will be used to decide claims for medical benefits (including pre-service and concurrent care claims). However, the Member should use the appeals procedures described in this Booklet to contest a denial of your claim for benefits.

The Member should be aware that, as described below, different types of claims may have different claims timeframes. Make sure that you understand what information you or your healthcare provider need to provide Anthem BCBS, and how long Anthem BCBS may take to give you a decision on your claim. If Anthem BCBS needs more information from you or your healthcare provider to process your claim, you may have a specific timeframe in which you must provide the additional information.

If you or your covered Dependent need medical treatment or plan benefits that requires pre-authorization (including hospitalizations), the Member should consult Anthem BCBS and follow instructions closely to ensure that you receive the maximum benefits available under the Benefit Program.

1. **Urgent Care Claims:** If the Member's claim is Urgent (as defined below) upon receipt of the necessary information, Anthem BCBS will notify you and the Provider of record of its initial decision as soon as possible, but no later than 2 business days or 72 hours, whichever is earlier, after receipt of your claim, or your request for Appeal. An Urgent Care claim is one which, if not decided quickly (i) could seriously jeopardize your life or health or ability to regain maximum function, or (ii) in the opinion of a physician familiar with your condition, would subject you to severe pain that cannot be adequately managed without the requested care or treatment. Any claim that a physician with knowledge of the Member's medical condition determines is an Urgent Care claim will be treated as an Urgent Care claim by Anthem BCBS. In the case of an Urgent Care claim, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.
 - a. **Insufficient Information:** If you or your authorized representative fails to provide sufficient information to determine whether your claim is covered under the Benefit Program, Anthem BCBS will notify you (or your representative) and the Provider of record as soon as possible, but not later than 24 hours after the receipt of the claim by Anthem BCBS. You will have no less than 48 hours to provide the information specified by Anthem BCBS. Anthem BCBS will notify you and your representative of the benefit decision as soon as possible, but in no case later than 48 hours after the earlier of:
 - i. Anthem BCBS's receipt of the specified information, or
 - ii. the end of the period given to you to provide the specified additional information.

If you do not supply the requested information within the time given you, your claim will be denied.

- b. **Improper Procedure:** If the Member or the Member's authorized representative fail to follow the Anthem BCBS's procedures for filing an Urgent Care claim, Anthem BCBS will notify the Member (or your representative) within 24 hours. This notification will include a description of the proper procedures. The notification may be oral, unless written notification is requested.
 - c. **Notice:** In the case of an adverse benefit decision involving an Urgent Care claim, Anthem BCBS will notify the Member within 2 business days or 72 hours, whichever is earlier, after receipt of the claim request. If notification is oral, a written or electronic notification will be furnished to the Member and your representative not later than three days after the oral notification. The notice must contain the information described in Section 5 of these procedures.

Anthem BCBS will also provide a description of the expedited review process for Urgent Care claims. This expedited review process will permit an oral or written request for an expedited appeal, and the transmission of all necessary information, including Anthem BCBS's benefit decision on review, between Anthem BCBS and the Member by telephone, facsimile, or other available, similarly expedient methods.

2. Pre-Service Claims: If the Member's claim for coverage or benefits is not Urgent, but pre-approval or prior authorization is required before medical care can be received or as a condition of payment under the Benefit Program's terms (a "pre-service claim"), upon receipt of the necessary information, your pre-service claim will be decided as soon as possible but no later than 2 business days or 15 days, whichever is earlier, after receipt of the claim by Anthem BCBS. This period can be extended for up to an additional 15 days for matters beyond Anthem BCBS's control if you (or your representative) and the Provider of record are notified before the expiration of the initial 15-day period of the circumstances that require the extension and the date by which Anthem BCBS expects to reach a decision.
 - a. Insufficient Information: If Anthem BCBS requires an extension because of the Member's failure to submit information necessary to decide the claim, the notice of extension must specifically describe the required information, and you (or your representative) and the Provider of record will be given at least 45 days from receipt of the notice to provide the specified information. If the Member does not supply the requested information within the time given, your claim will be denied.
 - b. Improper Procedure: If the Member or the Member's authorized representative fails to follow the claims procedure for filing a pre-service claim, Anthem BCBS must notify the Member (or your representative) within 5 days of the failure and the proper procedures. Notification may be oral, unless written notification is requested.
 - c. Notice: An adverse benefit decision must contain the information described in Section 5 of these procedures.
3. Post Service Claims: If the Member files a claim for benefits after services have been rendered (a "post service claim"), the claim will be decided no later than 30 days after receipt of the claim by Anthem BCBS. This period can be extended for up to an additional 15 days for matters beyond Anthem BCBS's control if you (or your representative) and the Provider of record are notified before the expiration of the initial 30-day period of the circumstances that require the extension and the date by which Anthem BCBS expects to reach a decision.
 - a. Insufficient Information: If Anthem BCBS requires an extension because of the Member's failure to submit information necessary to decide the claim, the notice of extension must specifically describe the required information, and the Member (or your representative) and the Provider of record will be given at least 45 days from receipt of the notice to provide the specified information. If the Member does not supply the requested information within the time given, your claim will be denied.
 - b. Notice: An adverse benefit decision must contain the information described in Section 5 of these procedures.
4. Concurrent Care Claims: A claim that involves care or treatment that will be provided on an ongoing basis over a period of time or for a certain number of treatments is known as a "Concurrent Care claim".

Any reduction or termination by Anthem BCBS of a previously covered course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit decision. Anthem BCBS will notify the Member (or your representative) and the Provider of record sufficiently in advance of a reduction or termination of this ongoing care to allow the Member (or your representative) an opportunity to appeal and obtain a decision on review of that adverse benefit decision before the benefit is reduced or terminated.

A request by the Member to extend an ongoing course of treatment that was previously approved for a specific period of time or number of treatments will be handled as follows:

- a. Involving Urgent Care: If Anthem BCBS notifies the Member (or your representative) that an ongoing course of treatment is to be reduced or eliminated and that treatment involves Urgent Care, the Member's request to extend the course of treatment will be decided as soon as possible, taking into account the medical exigencies, but no later than 24 hours after Anthem BCBS receives the claim as long as the claim is made to Anthem BCBS at least 24 hours before the expiration of the prescribed period of time or number

of treatments. If the Member's request for extended treatment is not made at least 24 hours before the expiration of the prescribed period of time or number of treatments, the Member's request will follow the non-concurrent care urgent care timeframes.

- b. Not Involving Urgent Care: The Member's request will be considered a new claim and will be decided according to post-service or pre-service timeframes, which ever applies.
 - c. Notice: In the case of an adverse benefit decision concerning a request to extend the course of treatment, whether involving Urgent Care or not, notification must contain the information described in Section 5 of these procedures.
5. Content of Notice of Adverse Benefit Decision: If the Member receives an adverse benefit decision the Member (or your representative) and the Provider of record will receive a written or electronic notice that:
- a. states the specific reason or reasons for the denial;
 - b. refers to the specific Plan provisions on which the benefit decision is based;
 - c. describes any additional information or material necessary to perfect the claim and explain why this information is necessary; and
 - d. describes Anthem BCBS's appeal procedures, time limits, and the Member's right to sue under Section 502(a) of ERISA following an adverse benefit decision on review.

If an internal rule, guideline, protocol, or other similar criteria were relied on in making the adverse decision, Anthem BCBS will either provide a copy of this rule, guideline, protocol, etc. or state that a copy will be provided without charge upon the Member's request.

If the adverse benefit decision is based on medical necessity or experimental treatment or a similar exclusion or limit, Anthem BCBS will either explain the scientific or clinical judgment for the decision, applying the terms of the Benefit Program to the Member's medical circumstances, or state that this explanation will be provided without charge upon the Member's request.

In the case of an adverse benefit decision involving an Urgent Care claim, Anthem BCBS will provide a description of the expedited review process for Urgent Care claims. This expedited review process will permit:

- a. an oral or written request for an expedited appeal of an adverse decision of an Urgent Care claim; and
- b. the transmission of all necessary information, including Anthem BCBS's benefit decision on review, between Anthem BCBS and the Member (or your representative) or the Provider of record by telephone, facsimile, or other available, similarly expedient methods.

Participating Physician, Providers and Hospitals

When you receive Covered Services from a Participating Physician, Provider or Hospital the Physician or Provider shall file the claim with Anthem BCBS. Any payment due under this Benefit Program shall be made directly to the Participating Physician, Provider or Hospital.

If further review of a claim is requested the Member should first contact Member Services. If resolution is not met, the Member should follow the guidelines set forth in the Grievance And External Review Process section of this Booklet.

Benefits for Covered Services will be reimbursed based on the Maximum Allowed Amount for Participating Physicians, Providers or Hospitals.

Non-Participating Physicians, Providers and Hospitals

Claims must be submitted by the Member when a Member receives Covered Services from a Non-Participating Physician, Provider or Hospital. The Member should obtain a complete itemized bill for services (charge card receipts and “balance due” statement are not acceptable) from the Physician, Provider or Hospital. The itemized bill, along with your name and identification number should be submitted in accordance with the Payment of Covered Services Section of the Booklet.

In some instances the Non-Participating Provider may file the claim directly to Anthem BCBS and any payment due under the Benefit Program shall be made directly to the Non-Participating Provider.

Benefits for Covered Services will be reimbursed based on the Maximum Allowed Amount for Non-Participating Physicians, Providers or Hospitals. Hospitals outside the United States are eligible to receive the Maximum Allowed Amount based on the rate of exchange.

If further review of a claim is requested the Member should first contact Member Services. If resolution is not met, the Member should follow the guidelines set forth in the Grievance And External Review Process section of the Booklet.

Payment for Covered Services

Anthem BCBS will make the payment for Covered Services under the Benefit Program on behalf of the Employer. We will make benefit payments directly to In-Network (Participating) Providers for Covered Services.

However, if you use an Out-of-Network (Non-Participating) Provider, we may make benefit payments directly to you. You will then be responsible for payment to the Out-of-Network Provider. Anthem BCBS reserves the right to make payments on behalf of the Employer directly to the Member at Anthem BCBS’s discretion. In certain situations where a Dependent child receives Covered Services from an Out-of-Network Provider, Anthem BCBS may send payments and claim notifications directly to a designated representative or the custodial parent, even if that parent is not a Member. You cannot assign your right to benefits to anyone else, except as required by a Qualified Medical Child Support Order as defined by ERISA or any applicable law.

Any benefit payments made us for Covered Services will discharge the Benefit Program’s obligation for Covered Services.

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

In order to be considered for payment, claims submitted by a Member for payment for Covered Services provided by an Out-of-Network Provider must be received by Anthem BCBS within 2 years from the date the Covered Services were performed. Claims for Covered Services more than 2 years after the date the services were performed shall not be covered or paid. Claims for Covered Services must be submitted to:

Anthem Blue Cross and Blue Shield
P.O. Box 726
North Haven, CT 06473

Anthem BCBS will not routinely issue a benefit payment, on behalf of the Employer under the Benefit Program, of less than \$1.00 except upon written request from the Member.

Paper Claims, for benefits for Covered Services provided to a Member, will be processed within sixty (60) days of the date the claim is received by Anthem BCBS. However, if additional information is needed to process and pay the claim, Anthem BCBS will send the claimant a written notice within thirty (30) days after receiving the claim, requesting the additional information required to process the claim. Upon receiving the requested information, Anthem BCBS will pay the claim within thirty (30) days.

Electronic claims, for benefits for Covered Services provided to a Member, will be processed within twenty (20) days of Anthem BCBS receiving them. If the claim does not include all required information, Anthem BCBS will send the claimant a written notice requesting the information be sent within ten (10) days. Upon receiving the requested information, Anthem BCBS will pay the claim within ten (10) days.

If the time to process a health claim is extended because the Member has not submitted requested information, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent to the Member until the date Anthem BCBS receives the Member's response. Anthem BCBS will make a claim decision within fifteen (15) days after receipt of the requested information. Members should submit the requested information within forty-five (45) days of receipt of the request.

Claim Overpayments

When the Benefit Program has made payments for Covered Services either in error or in excess of the maximum amount of payment necessary to satisfy the provisions of this Benefit Program, the Benefit Program has the right to recover these payments from one or more of the following as may be appropriate. The Benefit Program will not attempt to recover from any Member or Provider overpayments not made to or held by such Member or Provider. Overpayments may be recovered from:

- Any person to or for whom such payments were made;
- Any insurance companies; or
- Any other organizations.

The Benefit Program's right to recover may include subtracting from future benefits payments the amount the Benefit Program has paid in error or in excess. The Subscriber personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure the Benefit Program's right to recover any erroneous or excess payments.

Under BlueCard, recoveries made from a Blue Cross and/or Blue Shield plan in the BlueCard program or from participating providers of a Blue Cross and/or Blue Shield plan in the BlueCard program can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Blue Cross and/or Blue Shield plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

Anthem BCBS has the right to enforce the Benefit Program's rights under this provision.

Claim Denials

If benefits are denied, in whole or in part, Anthem BCBS will send the Member a written notice within the established time periods described in the section Payment for Covered Services. The Member or the Member's duly authorized representative may appeal the denial as described in the Grievance And External Review Process section. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and if applicable, the Member's right to bring civil action under ERISA section 502(a).

If the denial involves a utilization review determination, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge;

- that an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Member upon request and at no charge.

Claims Review

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

Claim Forms

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

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

INTER-PLAN ARRANGEMENTS

Out-of-Area Services - Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements”. These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you access healthcare services outside the geographic area we serve (the “Anthem Service Area”), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described in the sections below.

When you receive care outside of the Anthem service area, you will receive it from one of two kinds of Providers. Most Providers (“participating Providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some Providers (“Non-participating Providers”) don’t contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility - Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for (a) contracting with its Providers, and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem service area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

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

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under the BlueCard Program section) made available to Anthem by the Host Blue.

Special Cases: Value-Based Programs - Blue Card® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Non-Participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's service area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services, as Deductible, Copayment, or Coinsurance, will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem service area, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment we make for the Covered Services as set forth in this paragraph.

BlueCard Global Core ® Program

If you plan to travel outside the United States, call Member Services to find out your BlueCard Global Core Program benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification card with you.

When you are traveling abroad and need medical care, you can call the BlueCard Global Core Program Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

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

Please refer to the Managed Care section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with BlueCard Global Core Program

In most cases, when you arrange inpatient hospital care with BlueCard Global Core Program, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

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

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Global Core Program; and
- Outpatient services.

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

When you need BlueCard Global Core Program claim forms you can get international claims forms in the following ways:

- Call the BlueCard Global Core Program Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

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

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network health care Providers and the information you need to make the best decisions for your health. As a Member, you should also take an active role in your care.

You have the right to:

- Speak freely and privately with your health care Providers about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Benefit Program.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies and state and Federal laws.
- 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 health care Providers.
 - Your rights and responsibilities.
 - The rules of your health Plan.
 - The way your health Plan works.
- Make a complaint or file an appeal about:
 - Your health Plan and any care you receive.
 - Any Covered Service or benefit decision that your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may get in the future. This includes asking your Doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.
- Get help at any time, by:
 - Contacting Us by calling the Member Services number on your ID card or visiting Anthem.com; or
 - Contacting your local insurance department

Phone: 800-203-3447

Write: State of Connecticut Insurance Department

PO Box 816

Hartford, CT 06142-0816

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your 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 health care plan that you have agreed on with your 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 eligible for under your health Plan. This may include information about other health insurance benefits you have along with your coverage with us.
- Inform Member Services if you have any changes to your name, address or family members covered under your Benefit Program.

If you would like more information, have comments, 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.

We want to provide high quality benefits and customer service to our Members. Benefits and coverage for services given under the Benefit Program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

GRIEVANCE AND EXTERNAL REVIEW PROCESS

You may have questions about your Benefit Program. Since questions can often be handled informally, these questions may be addressed by contacting Member Services, please call the number on the back of your Identification Card. In addition, information about the following the Grievance and External Review Procedures, also known as the Appeal Process, may be obtained by contacting Member Services.

Rights Available to Members

You may ask for and get copies of all documents including the actual benefit provision, guideline, protocol or other similar criterion on which an adverse coverage decision was based. If you prefer, any other person you choose may ask for this information. We will send this information within five business days after receiving your request. We will send this information within one calendar day after receiving your request about a final adverse coverage decision for:

- An admission, availability of care, continued stay, or health care service for which you received emergency services but haven't been discharged from a facility; or
- A denial of coverage based on a decision that the recommended or requested health care service or treatment is experimental or investigational and your treating provider certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated.

We will send the information by fax, electronic means or any other fast method.

If you don't agree with our coverage decision, you have the right to ask for a grievance. The review of your grievance may change our previous coverage decision.

Other Helpful Resources

Whether or not you use the grievance rights available to you, you may contact the Consumer Affairs Division of the Connecticut Insurance Department or the Connecticut Office of the Health Care Advocate at any time. You may also benefit from free assistance with filing a grievance.

Consumer Affairs Division of the Connecticut Insurance Department

Address: P.O. Box 816
Hartford, CT 06142-0816
Phone: 860-297-3900 (local)
800-203-3447 (toll-free)
Email: cid.ca@ct.gov

Connecticut Office of the Health Care Advocate

Address: P.O. Box 1543
Hartford, CT 06144
Phone: 866-466-4446 (toll-free)
Email: Healthcare.advocate@ct.gov

If You Have a Complaint or An Appeal

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Benefit Program or a service you have received. In those cases, please call Member Services at the phone number on your Identification Card. We will try to resolve your complaint informally. If you are not satisfied with the resolution of your complaint, you have the right to file a grievance (also known as an appeal). You must file a grievance within 180 calendar days from the date you get a decision from us that you do not agree with. The review of your grievance may change our previous coverage decision.

Include the following details with your grievance if you have them:

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree;
- The specific reason(s) why you don't agree with the decision; and
- Any written comments, documents or other relevant information to support the request.

At any time, you can name someone to act for you. You must do this in writing.

To file a grievance, you, your doctor, or any person you choose (your authorized representative) can request a grievance in writing or by calling Member Services at the phone number on your Identification Card. Your grievance should be sent to one of the following addresses:

For Medical and Prescription Drug or Pharmacy Issues:

Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 1038
North Haven, CT 06473-4201

For Mental Health and Substance Abuse Issues:

Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 2100
North Haven, CT 06473-4201

How are Grievances Handled?

If your grievance is based on medical necessity, the appropriate clinical peer will review it. A clinical peer is a doctor or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. For a substance use or mental health disorder, the clinical peer will have additional qualifications. All relevant information given to us by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. If your grievance involves a substance use or mental health disorder, we will use the required criteria to review your request.

If your grievance is not based on medical necessity, we will send it for appropriate administrative review.

We may reach out to any providers who may have additional information to support your grievance. The reviewers will not have been involved in the initial decision. They also will not be a subordinate (in a lower position) of the person who made the initial decision.

Before issuing a decision on a grievance of an adverse coverage decision based on medical necessity, we will give you, free of charge, any new or additional evidence relied upon or scientific or clinical rationale. We will give you this information in advance of the grievance resolution date. This will allow you a reasonable amount of time to respond before that date.

Standard (Non-urgent) Grievance

You may ask for a standard grievance (a grievance that is not urgent) for a coverage decision you don't agree with. You can also ask for a standard grievance for a rescission (ending or canceling) of coverage. Your request must be in writing. In your request, please let us know that you are asking for a grievance. Include any additional information you have to support your request.

We will respond to a grievance for a medical necessity decision within 30 calendar days from the date we get the request. If the decision is not based on medical necessity, we will respond within 20 business days from the date we get the request. Our response will be in writing.

Urgent (Expedited) Grievances

An urgent grievance is available if you have not had or are currently receiving services and the timeframe of a standard grievance review could:

- Seriously jeopardize (harm) your life or health;
- Jeopardize your ability to regain maximum function; or
- In the opinion of a health care professional with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the health care service or treatment being requested.

We will let you know our decision within 72 hours of receiving a request for an urgent grievance described in this section. We will let you know our decision by phone, fax, or any other available means.

For urgent grievances related to Mental Health and Substance Abuse disorders please see the next section.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help us handle the review fast.

Mental Health Disorder and Substance Use Disorder

An urgent grievance is also available for:

- Substance use disorder or co-occurring mental health disorder; or
- Inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a Member from requiring an inpatient setting in connection with a mental health disorder.

We will let you know our decision within 24 hours of receiving a request for an urgent grievance described in this section. We will let you know our decision by phone, fax, or any other available means.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help us handle the review fast.

External Review

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

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

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

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

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

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

Anthem Blue Cross and Blue Shield
ATTN: Grievance & Appeals/External Appeals
P.O. Box 1038
North Haven, CT 06473

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws.

Prescription Drug List Exceptions

Please refer to the “Prescription Drug List” section in “Prescription Drug Rider” section for the process to submit an exception request for Drugs not on the Prescription Drug List.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from the Department of Health and Human Services and Department of Labor.

ELIGIBILITY AND ENROLLMENT – Adding Members

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

Who is Eligible for Coverage

The Subscriber

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

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

Dependents

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

- The Subscriber's spouse. For information on spousal eligibility please contact the Employer.
- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Employer has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law and who has not obtained health insurance through their own employer.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the Plan renewal date once they reach 26 years of age. Coverage may be continued past the age limit in the following circumstances:

For those already enrolled Dependents who cannot work to support themselves due to mental or physical handicap. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

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

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

Types of Coverage

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

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse;
- Subscriber and child(ren);
- Subscriber and family.

When You Can Enroll

Initial Enrollment

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

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

Open Enrollment

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

Special Enrollment Periods

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

Special Enrollment is available for eligible individuals who:

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

Important Notes about Special Enrollment:

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

Medicaid and Children's Health Insurance Program Special Enrollment

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

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

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

Late Enrollees

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

Members Covered Under the Employer's Prior Plan

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

If at the time of the Effective Date of coverage you or your covered dependents become eligible for coverage under this Plan while inpatient at a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility, the coverage under this Plan will be effective. To the extent that the costs of hospitalization, inpatient stay or any medical care relating to that hospitalization or inpatient stay are the responsibility of a previous carrier, the payment of these claims will be coordinated with the previous carrier in accordance with State law. You should notify us when an inpatient stay under these circumstances occurs.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth a child, you should submit an application / change form to the Employer within 31 days to add the newborn to your Plan.

Note: Although this 31 day requirement does not apply if there are no additional Fees required, we still need an application / change form to make sure the Employer has accurate records and are able to cover your claims.

Adopted Children

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

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send the Employer the completed application / change form within 60 days of the event.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 60 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

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

Updating Coverage and/or Removing Dependents

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

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

Failure to notify the Employer of individuals no longer eligible for services will not obligate the Plan to cover such services, even if Fees are received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

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

Statements and Forms

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

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

TERMINATION AND CONTINUATION OF COVERAGE

Termination

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

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

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

Removal of Members

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

Continuation of Coverage Under Federal Law (COBRA)

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

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health Plan. It can also become available to other Members of your family, who are covered under the

Employer's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Employer.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

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

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

Qualifying Event	Length of Availability of Coverage
<p><u>For Subscribers:</u></p> <p>Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked</p>	<p>18 months</p>
<p><u>For Dependents:</u></p> <p>A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked</p> <p>Covered Subscriber's Entitlement to Medicare</p> <p>Divorce or Legal Separation</p> <p>Death of a Covered Subscriber</p>	<p>18 months</p> <p>36 months</p> <p>36 months</p> <p>36 months</p>
<p><u>For Dependent Children:</u></p> <p>Loss of Dependent Child Status</p>	<p>36 months</p>

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

If Your Employer Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy

results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

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

Notification Requirements

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

You Must Give Notice of Some Qualifying Events

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

Electing COBRA Continuation Coverage

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

Disability extension of 18-month period of continuation coverage

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

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

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

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

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.

If You Have Questions

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

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

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

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

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

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

Maximum Period of Coverage During a Military Leave

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

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

Reinstatement of Coverage Following a Military Leave

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

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

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

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

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

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

Family and Medical Leave Act of 1993

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

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

GENERAL PROVISIONS

Assignment

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

Care Coordination

We pay, on behalf of the Employer, In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Clerical Errors

Clerical errors or reasonable delays in recording or reporting dates made in connection with the Benefit Program, whether by Anthem BCBS, the Member, or an Employer will not invalidate coverage that would otherwise have been effective, or continue coverage that would otherwise have terminated, or should not have been in effect. A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Benefit Program.

Confidentiality and Release of Information

By your application, you have agreed to allow your Providers to give us the needed information about the care they provide, to you to the extent permitted by law.

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

Your medical information may be released to professional peer review organizations and to the Employer for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Employer to conduct the review or audit.

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

Conformity with Law

Any term of the Benefit Program which is in conflict with the federal law will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

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

Form or Content of Booklet

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

Government Programs

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

Identification Cards

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

Limitation of Actions

No legal action may be taken to recover benefits within 60 days after notice of claim has been given, nor may any action be brought after two years from the date Covered Services are received.

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.

Modifications

The plan sponsor may change the benefits described in this Booklet and the Member will be informed of such changes as required by law. This Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Benefit Program or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

Anthem BCBS and the Benefit Program are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem or the Benefit Program based on the actions of a Provider of health care, services, or supplies. The Benefit Program and the Claims Administrator's Network Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of the Benefit Program. The Benefit Program will not be liable for any act or omission of any Provider or any agent or employee of a Provider. Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Payment Innovation Programs

We pay, on behalf of the Employer, In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Policies and Procedures

We, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Benefit Program with which a Member shall comply.

Under the terms of the Administrative Service Agreement with your Employer, we have the authority to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of our ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Benefit Program. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. We reserve the right to discontinue a pilot initiative at any time without advance notice to Employer.

Program Incentives

We, on behalf of the Employer, may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Benefit Program. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (Employer -Member-Anthem)

Neither the Employer nor any Member is the agent or representative of the Benefit Program. The Employer is responsible for passing information to the Member. For example, if the Benefit Program gives notice to the Employer, it is the Employer's responsibility to pass that information to the Member. The Employer is also responsible for passing eligibility data to the Benefit Program in a timely manner. If the Employer does not provide the Benefit Program with timely enrollment and termination information, the Benefit Program is not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Reservation of Discretionary Authority

We, as the Claims Administrator, shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the operation of the Benefit Program and interpretation of the Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine questions arising under the Benefit Program, to resolve Member Appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the Booklet of the Benefit Program. A specific limitation or exclusion will override more general benefit language. We have complete discretion to interpret the Booklet. Our determination may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Benefit Program's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures

Right of Recovery

Whenever payment has been made in error, the Benefit Program will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

The Benefit Program has oversight responsibility for compliance with Provider and vendor and subcontractor contracts. The Benefit Program may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible. Additionally, The Benefit Program has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Benefit Program will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

Anthem BCBS, as Claims Administrator, has the right to enforce the Benefit Program's rights under this provision.

Unauthorized Use of Identification Card

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

Value-Added Programs

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

Value of Covered Services

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

Voluntary Clinical Quality Programs

The Administrator may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under this Benefit Program. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which you are encouraged to use for health and wellness related activities or items. 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 also be offered a home visit appointment to collect such specimens and complete biometric screenings. 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 or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, the Claims Administrator recommends that you consult your tax advisor.

Voluntary Wellness Incentive Programs

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

Waiver

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

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:01 a.m. and ends at 12:00 a.m. eastern standard time.

OPTIONAL PROVISION(S)

Optional Provisions refer to Preferred Provider Program addenda for benefits for Covered Services which are provided in addition to, or to supersede, Preferred Provider Program Covered Services. The Schedules of Benefits of these Optional Provision Sections are not subject to the Preferred Provider Program Schedule of Benefits.

A Member is entitled to benefits for Covered Services as described in these Optional Provision Sections and related Schedules of Benefits.

These Optional Provision Sections are subject to the terms and conditions of the following Preferred Provider Program Benefits Sections: Acceptance, Eligibility, Exclusions, Conditions and Limitations, Coordination of Benefits and General Provisions.

These Optional Provision Sections are not subject to the terms and conditions of the Preferred Provider Program of Benefits Section: Preferred Provider Program Description.

Optional Provision benefits prevail until a per Member maximum has been reached. Preferred Provider Program benefits will become effective after a Member's Optional Provision maximum is reached, if applicable.

PRESCRIPTION DRUG RIDER

Issued By:

Anthem Health Plans, Inc. d/b/a
Anthem Blue Cross and Blue Shield
P.O. Box 541
North Haven, Connecticut 06473-0541

Introduction

This Prescription Drug Rider makes benefits available for the purchase of Prescription Drugs and Maintenance Prescription Drugs, subject to the terms and conditions of the Summary Booklet and this Rider, when the Employer Group has selected this Rider as part of its Benefit Program.

This Prescription Drug Rider ensures appropriate medications and quantities of the Prescription Drug are dispensed within a time limit. In addition to Prior Authorization, Anthem BCBS conducts drug utilization review when the prescription is presented to be filled at a Pharmacy or through the designated mail order vendor and by audit of submitted claims. The Copayments or Coinsurance amount, whichever is applicable, to Covered Drugs under this Rider are separated into multiple tiers.

Anthem BCBS 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 assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

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

This Rider is not available to any person who does not have coverage under the Benefit Program. This Rider replaces and supersedes any other Rider of similar coverage that may have been issued prior to the Effective Date of this Rider. The Summary Booklet is amended as described herein.

Pharmacy Benefits Management

The Pharmacy benefits available to you under this Rider are managed by Anthem BCBS's affiliate. They are a Pharmacy benefits management company with which Anthem BCBS contracts to manage Pharmacy benefits. The Pharmacy benefits manager has a nationwide network of retail Pharmacies, Specialty Pharmacies, a mail order Pharmacy, and also provides clinical services that include tier management.

Some of the services the Pharmacy benefits manager provides in consultation with Anthem BCBS include making recommendations and updates to and the Prescription Drug List; managing a network of retail Pharmacies, Specialty Pharmacies, and operating a Mail Order Pharmacy; services to promote and assist Covered Persons in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns; and Special Programs.

The Member may also request a copy of the Prescription Drug List by calling a Members Services/Customer Service representative at the telephone number on the back of the ID card or online at the Anthem BCBS website: www.Anthem.com. The Prescription Drug List is subject to periodic review and amendment. Inclusion of a drug or related item on the Prescription Drug List is not a guarantee of coverage. Refer to the Prescription Drug benefit section in this Rider for information on coverage, limitations and exclusions.

Special Programs

From time to time we may initiate various programs to encourage Members 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 Copayment or Coinsurance amounts, whichever is applicable, for certain drugs or preferred products for a limited period of time.

1/2 Tab Program

The Half-Tablet Program will allow Members to pay a reduced Copayment or Coinsurance amount, whichever is applicable, 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 National 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 contact Member Services/Customer Service.

PRESCRIPTION DRUG DEFINITIONS

In addition to the defined terms listed in the Definitions Section of the Summary Booklet, the following definitions also apply:

BIOSIMILAR(S):

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

BRAND NAME DRUGS (Brand Name Prescription Drugs):

Prescription Drugs that we classify as Brand Name Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

CALENDAR YEAR:

The term Calendar Year means a period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

COINSURANCE:

The term Coinsurance means the fixed percentage of the Maximum Allowable Amount for Covered Drugs which the Covered Person is required to pay as shown in the Schedule of Prescription Drug Benefits.

CONTROLLED SUBSTANCES

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

COPAYMENT:

For purposes of describing the benefits contained in this Rider, the term Copayment is amended to mean the fixed fee, as shown on the Schedule of Prescription Drug Benefits, paid by a Covered Person for each separate Prescription Drug order, or refill of a Covered Drug.

DESIGNATED PHARMACY PROVIDER:

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

GENERIC DRUGS (Generic Prescription Drugs):

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

INTERCHANGEABLE BIOLOGIC PRODUCT:

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

MAINTENANCE PHARMACY:

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90 day supply of Maintenance Medication.

MAINTENANCE PRESCRIPTION DRUG:

The term Maintenance Prescription Drug means 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.

MEMBER:

For the purposes of describing the benefits contained in this Rider, the term Member is amended to mean either a Covered Person or his or her Dependent enrolled in and eligible for benefits for Covered Drugs under this Rider.

NETWORK SPECIALTY PHARMACY:

The term Network Specialty Pharmacy means any appropriately licensed Pharmacy which has entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to render Specialty Drug services and certain administrative functions.

NEW FDA APPROVED DRUG PRODUCT OR TECHNOLOGY:

The term New FDA Approved Drug Product or Technology means the first release of the Brand Name product or technology upon the initial FDA New Drug Approval or other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

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

NON-NETWORK SPECIALTY PHARMACY:

The term Non-Network Specialty Pharmacy means any appropriately licensed Pharmacy which has not entered into a contractual agreement with Anthem BCBS, or its pharmacy benefits manager designee, to provide Specialty Drug services and certain administrative functions.

NON-PARTICIPATING PHARMACY:

The term Non-Participating Pharmacy means any appropriately licensed Pharmacy that is not a Participating Pharmacy under the terms and conditions of this Rider.

PARTICIPATING PHARMACY:

The term Participating Pharmacy means a Pharmacy, acceptable as a Participating Pharmacy by Anthem BCBS, or its pharmacy benefits manager designee, to provide Covered Drugs to Covered Persons under the terms and conditions of this Rider.

PHARMACY:

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

PHARMACY AND THERAPEUTICS (P&T) PROCESS:

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

PRESCRIPTION DRUG(S) (Also referred to as Legend Drug(s)):

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription."

This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, requires a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin, diabetic supplies, and syringes.

PRESCRIPTION ORDER

A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

PRIOR AUTHORIZATION (PRIOR AUTHORIZED):

The term Prior Authorization (Prior Authorized) means that prior approval has been obtained from Anthem BCBS, which enables a Covered Person to receive benefits for certain Covered Drugs.

RIDER:

The term Rider means an additional benefit, which has been purchased by the Employer Group.

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 required additional patient support-any or all of which make the drug difficult to obtain through traditional pharmacies.

PRESCRIPTION DRUG BENEFITS

Following payment of the amounts shown on the Schedule of Prescription Drug Benefits for each Covered Drug, Anthem BCBS will pay an amount as specified in the subsections entitled Participating Pharmacy or Non-Participating Pharmacy Benefits of this section. The Covered Person should refer to the Schedule of Prescription Drug Benefits for the applicable Copayment or Coinsurance amounts, whichever is applicable. A Covered Person's rights to Covered Drugs as provided in this Rider are subject to the terms and conditions of this Rider and the Managed Care section in the Summary Booklet.

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

Diabetic drugs and supplies

In addition to benefits for Covered Drugs for the treatment of diabetes, benefits are also available for Medically Necessary equipment and supplies for the treatment of diabetes.

Infertility drugs and oral chemotherapy

Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness (Any step therapy regimen shall be implemented consistent with applicable law),
- Use of a Prescription Drug List (as described below).
- You or your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Benefit Program. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services. Such changes are subject to the terms and conditions provided in this Booklet.

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

Specialty Pharmacy Network

You or your Physician order your Specialty Drugs directly from a Participating Specialty Pharmacy, by calling Member Services/Customer Service Department at the number located on your identification card. If you or your physician orders your Specialty Drugs from a Participating Specialty 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.

The amount of benefits paid is based upon whether you receive the Covered Services from a Participating Pharmacy, a Network Specialty Pharmacy, a Non-Participating Pharmacy, a Non-Network Specialty Pharmacy, or the designated mail order vendor. Please refer to the Prescription Drug benefit sections in this Rider for information on coverage; limitations; and exclusions.

Therapeutic Substitution of Drugs

Your Pharmacy benefit includes a therapeutic drug substitution program approved by Anthem BCBS and managed by the Pharmacy benefits manager. This voluntary program designed to inform Covered Persons and Physicians about tiering alternatives. The Pharmacy benefits manager may contact the Covered Person, the Covered Person's representative, or the prescribing Physician to make the Covered Person aware of tiering substitution options. Therapeutic substitution may also be initiated at the time the Prescription Drug is dispensed. Only the Covered Person and the Covered Person's Physician can determine whether the therapeutic substitution is appropriate.

For a list of therapeutic drug substitutions that have been identified, contact a Member Services/Customer Service representative by calling the telephone number on the back of the ID Card. The Covered Person may also review the list of therapeutic drug substitutions on the Pharmacy benefits manager's website at www.Anthem.com. The therapeutic drug substitution list is subject to periodic review and amendment.

Participating Pharmacy or Network Specialty Pharmacy Benefits

When a Covered Drug is dispensed by a Participating Pharmacy or Network Specialty Pharmacy, the following provisions apply:

1. Prescription drugs will always be dispensed as ordered by your physician. You may request, or your physician may order, the brand name drug. By law, generic and brand name drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. We reserve the right, in our sole discretion, to remove certain higher cost generic drugs from this policy.
2. In the event no Generic Prescription Drug is available, the Covered Person is responsible for the applicable Prescription Drug Copayment or Coinsurance amount, whichever is applicable, as shown on the Schedule of Prescription Drug Benefits and any amounts exceeding the maximum benefits payable by Anthem BCBS.
3. Certain Covered Drugs require Prior Authorization. When Prior Authorization is obtained and the Covered Drug is dispensed by a Participating Pharmacy or Network Specialty Pharmacy, the Participating Pharmacy or Network Specialty Pharmacy will accept the Maximum Allowable Amount and will make no charge to the Covered Person, except for any applicable Copayment or Coinsurance amounts, whichever is applicable, or amounts exceeding the maximum benefits payable by Anthem BCBS.
4. Payment for Covered Drugs will be made directly to the Participating Pharmacy or Network Specialty Pharmacy. The Covered Person may refer to the directory of Participating Pharmacies or contact his or her Member Services/Customer Service Department at the number located on his or her identification card to obtain a listing of Participating Pharmacies or Network Specialty Pharmacies.

Important Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, we may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network Pharmacy. We will contact you if we determine that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies we offer within 31 days, we will select a single In-Network Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the “Grievance And External Review Process” section of this Booklet.

In addition, if it is determined that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Providers for Controlled Substance Prescriptions may be limited. If this happens, the Plan may require you to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single In-Network Provider. The Claims Administrator will contact you if we determine that use of a single In-Network Provider is needed and give you options as to which In-Network Provider you may use. If you do not select one of the In-Network Providers offered within 31 days, a single In-Network Provider will be selected for you. If you disagree with this decision, you may ask us to reconsider it as outlined in the “Grievance and External Review Process” section of this Booklet.

Non-Participating Pharmacy or Non-Network Specialty Pharmacy Benefits

When a Covered Drug is dispensed by a Non-Participating Pharmacy or Non-Network Specialty Pharmacy, the following provisions apply:

1. Anthem BCBS requires that the Covered Person obtain the federally approved Generic Prescription Drug from the Non-Participating Pharmacy, Non-Network Specialty Pharmacy, or mail order vendor when a Prescription Drug order does not specify "No Substitution".
2. If the Physician does not specify "No Substitution" and the Prescription Drug is filled with a Brand Name Prescription Drug at the request of the Covered Person, even though a Federally approved generic equivalent medication is available, the Covered Person shall be responsible for the applicable Coinsurance amount, as shown on the Schedule of Prescription Drug Benefits.
3. In the event that no Generic Prescription Drug is available for the dispensing of a Prescription Drug, when the Covered Drug is dispensed a Covered Person is required to pay applicable Coinsurance amount as shown on the Schedule of Prescription Drug Benefits and any amounts exceeding the maximum benefits payable by Anthem BCBS.
4. A Physician may decide that a Brand Name Prescription Drug is Medically Necessary to identify or treat a Member's specific injury or illness. If the Physician writes "No Substitution", for a particular Prescription Drug for the Member, the Member is required to pay the applicable Coinsurance amount, for that particular Prescription Drug as shown on the Schedule of Prescription Drug Benefits.
5. Certain Covered Drugs require Prior Authorization. When Prior Authorization is obtained and the Covered Drug is dispensed by a Non-Participating Pharmacy or Non-Network Specialty Pharmacy, the Covered Person is required to pay the applicable Coinsurance amount shown on the Schedule of Prescription Drug Benefits and any amounts exceeding the maximum benefits payable by Anthem BCBS. Prescription drug claims submitted for payment that have not received Prior Authorization even though the Plan requires said authorization will not be deemed ineligible for payment solely because the claim did not receive Prior Authorization. However, if the Member fails to obtain Prior Authorization, the Pharmacy Benefits Manager will review the claim against medical necessity and other plan requirements (other than Prior Authorization) to determine if the claim is eligible for coverage under the plan. Please see the Covered Drugs Requiring Prior Authorization section of this Rider for additional information.

6. When a Medically Necessary Prescription Drug is dispensed by a Non-Participating Pharmacy or Non-Network Specialty Pharmacy, the Covered Person shall be responsible for his or her Coinsurance. Anthem BCBS shall pay the Maximum Allowable Amount that is payable to a Non-Participating Provider or Non-Network Specialty Pharmacy. The Covered Person shall be responsible for any difference between the Maximum Allowable Amount and the amount charged by the Non-Participating Pharmacy or Non-Network Specialty Pharmacy.
7. Claims must be filed with Anthem BCBS within two years after the Prescription Drug has been filled. Claims must include the Covered Person's name, Identification Card number, an original itemized bill and explanation including the name and quantity of the Prescription Drug. Covered Persons may contact the Member Services/Customer Service Department at the toll-free number listed on their Identification Card to obtain instructions on how to file a Non-Participating Pharmacy or Non-Network Specialty Pharmacy claim.
8. Anthem BCBS shall reimburse to the Covered Person the Maximum Allowable Amount for Non-Participating Providers or Non-Network Specialty Pharmacies for Covered Drugs after review and approval of the claim.

National Pharmacy Network

A Covered Person covered under this Rider may obtain Covered Drugs out-of-state at any Pharmacy participating in the National Pharmacy Network servicing Anthem BCBS Covered Persons.

A Covered Person may locate a participating out-of-state Pharmacy by calling the toll-free number listed on his or her identification card.

To obtain benefits, a Covered Person should show the participating out-of-state pharmacist his or her identification card. All Covered Drugs are subject to the applicable Copayment or Coinsurance amounts, whichever is applicable, as shown on the Schedule of Prescription Drug Benefits.

Voluntary Mail Order Program

A Covered Person may order a 1 to 100 day supply of any Covered Drug that is a Maintenance Prescription Drug from the designated mail order vendor subject to the applicable Copayment or Coinsurance amounts, whichever is applicable, and benefit maximum amount as shown on the Schedule of Prescription Drug Benefits. A Covered Person should refer to the mail order program brochure included with his or her Benefit Program materials for more information on this program, or call their Member Services/Customer Service Department at the number located on his or her identification card.

Tiers

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

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

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

Prescription Drug List

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

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

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

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Exception Request for a Drug not on the Prescription Drug List

If you or your Doctor believes you need a Prescription Drug that is not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the other Drugs that are on the List. We will make a coverage decision within 72 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills. Please see the “Grievance And External Review Process” section for more information.

You or your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the Benefit Program. We will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug, you have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. Please see the “Grievance And External Review Process” section for more information.

Coverage of a Drug approved as a result of your request or your Doctor’s request for an exception will only be provided if you are a Member enrolled under the Benefit Program.

Other Provisions

1. Anthem BCBS may require a Covered Person to furnish Anthem BCBS with any information about the diagnosis of any injury or illness and about the nature, quality, and quantity of the Prescription Drug prescribed.
2. Anthem BCBS shall not be liable for any claims, injury, demand or judgment based on tort, product liability, or other grounds (including warranty of merchantability), arising out of the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug dispensed under the provisions of this Rider.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

For purposes of this Rider, the Exclusions Section of the Summary Booklet is amended to include the following.

This Rider provides no benefits for any Prescription Drug that is:

1. Prescription Drugs requiring Prior Authorization which are obtained by the Covered Person but are not Prior Authorized by Anthem BCBS will not be considered Covered Drugs eligible for reimbursement under this Rider, unless otherwise specified in this Rider. The Covered Person should contact their Member Services/Customer Service Department at the number located on his or her identification card to obtain a listing of Covered Drugs requiring Prior Authorization.
2. Prescription Drugs which are dispensed to the Covered Person in quantities which exceed the applicable limits established by Anthem BCBS, in its sole discretion are not covered.
3. Dispensed before the Covered Person's Effective Date or after his or her termination date.
4. Refilled in excess of the number the Prescription Drug order calls for or refilled after one year from the date of such order.
5. A Pharmacy charge that is less than the applicable Copayment amount, as shown on the Schedule of Prescription Drug Benefits.
6. Covered by Workers' Compensation law or similar laws, or covered by Workers' Compensation coverage, even if the Covered Person chooses not to claim such benefits, except as may be otherwise required by law.
7. Furnished by the U.S. Veterans' Administration, except as may be otherwise required by law.
8. Dispensed or prescribed in a manner contrary to accepted medical and professional standards of practice.
9. Considered Experimental or Investigational by Anthem BCBS in its sole discretion. However, Prescription Drugs will not be considered Experimental if they have successfully completed a Phase III clinical trial of the Food and Drug Administration (FDA), for the illness or condition being treated, or the diagnosis for which it is being prescribed.
10. A drug that requires Federal or other governmental agency approval not granted at the time the drug was prescribed, or a drug that is approved by the Food and Drug Administration (FDA) for controlled studies only.
11. Provided in connection with any Hospital or Inpatient Facility.
12. Used in connection with weight control.
13. Used in connection with male or female sexual dysfunctions or inadequacies, or erectile dysfunctions or inadequacies, regardless of origin or cause.
14. A contraceptive or contraceptive device, that has not been approved by the Federal Food and Drug Administration (FDA), and is not prescribed by a licensed Physician.
15. An antibacterial soap/detergent, shampoo, toothpaste/gel, or mouthwash/rinse.
16. An appliance or device.
17. A hypodermic needle, syringe, or similar device, except when used for the administration of Covered Drugs when prescribed in accordance with the terms and conditions of the Managed Care section in the Summary Booklet.
18. An allergenic extract or vaccine.
19. Used solely to improve appearance or for cosmetic purposes.

20. Any other services or items of care not listed in this Rider.
21. Covered under any other section of the Summary Booklet.
22. **Administration Charges:** Charges for the administration of any Drug except for covered immunizations as approved by the Plan or the PBM.
23. **Charges Not Supported by Medical Records:** Charges for services not described in your medical records.
24. **Clinically-Equivalent Alternatives:** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most patients, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at.

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

25. **Compound Drugs:** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
26. **Contrary to Approved Medical and Professional Standards:** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
27. **Delivery Charges:** Charges for delivery of Prescription Drugs
28. **Drugs Over Quantity or Age Limits:** Drugs which are over any quantity or age limits set by the Benefit Program or us.
29. **Drugs Over the Quantity Prescribed or Refills After One Year:** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
30. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications:** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by us.
31. **Drugs That Do Not Need a Prescription:** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
32. **Family Members:** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
33. **Gene Therapy:** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
34. **Lost or Stolen Drugs:** Refills of lost or stolen Drugs.
35. **Non-Medically Necessary Services:** Services the Plan concludes are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
36. **Nutritional or Dietary Supplements:** Nutritional and/or dietary supplements, except as described in this Booklet or that must be cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
37. **Off label use:** Off label use, unless we must cover it by law or if we approve it.

38. **Onychomycosis Drugs:** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
39. **Over-the-Counter Items:** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend Drugs when any version or strength becomes available over the counter, unless otherwise required by law, or is otherwise determined by us to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to us, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care” benefit under federal law with a Prescription.

40. **Sex Change Drugs:** Prescription Drugs related to and performance of sex change operations including follow-up treatment, care and counseling, unless the Member has been diagnosed with gender dysphoria and all Medically Necessary criteria are met as determined by Anthem BCBS in accordance with generally accepted medical standards.

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version

This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish

Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic

يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD: 711).

Chinese

本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French

Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek

Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian

Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तिथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चित तिथियों तक कार्रवाई करने की ज़रूरत हो सकती है। आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Italian

Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Korean

이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish

Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Este aviso contém informações importantes sobre a sua candidatura ou benefícios. Preste atenção a datas importantes. Poderá ser necessário agir até determinadas datas para manter os seus benefícios ou gerir os custos. Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Russian

Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться

выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.
(TTY/TDD: 711)

Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese

Thông báo này có thông tin quan trọng về đơn đăng ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.