Anthem BlueCross BlueShield

Access Blue New England

Cost Sharing Schedule

This Cost Sharing Schedule is an important part of your Subscriber Certificate. Please keep this schedule with your Certificate, because it contains important information about coverage and limitations.

Cost Sharing Summary	YOUR COST* *Benefits are limited to the Maximum Allowable Benefit*
Visit Copayment Applies each time you visit your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist	$20 per visit
Specialty Visit Copayment Applies each time you visit a specialist who is not your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist. This Copayment also applies each time you visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.	$30 per visit
Urgent Care Facility Copayment Applies each time you visit a licensed hospital's urgent care facility in the Network for diagnosis, care and treatment of illness or injury.	$50 per visit
Emergency Room Copayment	$100 per visit
Inpatient Copayment	$250 per admission
Outpatient Surgery Copayment	$250 per admission
Inpatient Copayment and Outpatient Surgery Copayment (combined) Maximum	$250 per Member, per Contract Year $500 per family, per Contract Year
Out-of-Pocket Limit The Out-of-Pocket Limit includes all Copayments you pay during a Contract Year. It does not include your premium, amounts over the Maximum Allowable Benefit, or charges for noncovered services. Once the Out-of- Pocket Limit is satisfied, you will not have to pay additional Copayments for the rest of the Contract Year.	$6,350 per Member, per Contract Year $12,700 per family, per Contract Year
Pharmacy Benefit Cost Sharing You may purchase up to a 90-day supply of a covered prescription drug at one time, provided that the drug is a Covered Service, the quantity is ordered by your physician and the drug does not require Precertification from Anthem. • You pay one Copayment for each prescription filled (or refilled) up to a 30-day supply. • At a retail pharmacy, you pay two Copayments for a supply of 31 to 60 days and three Copayments for supplies of 61 to 90 days. • At a mail order pharmacy, you pay two Copayments for a 31 to 90 day fill or refill. Please see your Pharmacy Rider for complete information about your share of the cost for Covered Services purchased at a pharmacy.	
At a Retail Pharmacy or by Mail Order: Tier 1 Copayment Tier 2 Copayment Tier 3 Copayment	 $10 $30 $50

*Benefits are limited to the Maximum Allowable Benefit. If you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and charge.

The following is an outline of your coverage. Do not rely on this outline alone. Please read your Subscriber Certificate carefully, because important terms and limitations apply.

Coverage Outline	Your Cost*
Medical/Surgical Care	
I. Inpatient Services	
In a Short Term General Hospital (Facility charges for medical, surgical and maternity admissions)	Inpatient Copayment per admission
In a Skilled Nursing Facility (Facility charges) - Up to 100 Inpatient days per Member, per Calendar Year	
In a Physical Rehabilitation Facility (Facility charges) - Up to 100 Inpatient days per Member, per Calendar Year	
Inpatient Physician and Professional Services Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests (For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.)	You pay $0
II. Outpatient Services	
Preventive Care	
Preventive care and screenings as required by law including, but not limited to: Immunizations for babies, children and adults Cancer screenings such as mammograms and pap smears, routine colonoscopy and sigmoidoscopy screening including fecal occult blood tests, barium enema, and related prep kit and CT colonography (as appropriate) Routine physical exams for babies, children and adults, including an annual gynecological exam Routine hearing and vision screenings and other preventive care and screenings for infants, children, adolescents and women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration Lead screening and any other screening with an "A" or "B" rating from the United States Preventive Services Task Force including, but not limited to: screenings for breast cancer, cervical cancer, colorectal cancer, high blood pressure, type 2 diabetes mellitus, cholesterol, child and adult obesity Outpatient/office contraceptive services as required by law Nutrition counseling including nutrition counseling for eating disorders	You pay $0
Other preventive care: Travel and rabies immunizations Prostatic specific antigen (PSA) screening	You pay $0
Routine hearing exams	You pay $0

***Benefits are limited to the Maximum Allowable Benefit. If you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and charge.

Coverage Outline	Your Cost*
Other preventive care (continued)	
Routine vision exams One exam each Contract Year for Members 18 years old and younger; One exam every two Contract Years for Members 19 years old and older	You pay $0
Prescription Eyewear - Anthem covers $100 per Member every other Contract Year toward the cost of prescription eyewear (frames, lenses and contact lenses).	You pay any amount that exceeds Anthem's $100 allowance.
Diabetes management program	You pay $0
Medical/Surgical Care in a Physician's Office (in addition to the Preventive Care above)	
Medical exams, consultations, office surgery and anesthesia, medical treatments, telemedicine visits and Network Provider services at a Network Walk-In Center	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Laboratory and x-ray tests (including allergy testing and ultrasound)	
MRI, CT Scan, chemotherapy, medical supplies and drugs	
Contraceptive drugs and devices that must be administered in a provider's office (such as IUDs)	
Maternity care (prenatal and postpartum visits) Please see your Subscriber Certificate for information about total maternity care.	You pay no Visit Copayment or Specialty Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown for "Inpatient Services" (above) and "Outpatient Facility Care" (below).
Outpatient Facility Care in the Outpatient Department of a Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center (in addition to the Preventive Care above)	
Medical exams and consultations by a physician and telemedicine visits	Visit Copayment or Specialty Visit Copayment
Operating room for surgery or delivery of a baby	Outpatient Surgery Copayment per admission
Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRI, CT Scan, Facility charges, medical supplies, drugs, other ancillaries, observation	You pay $0
Laboratory and x-ray tests (including ultrasounds)	
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room at a Network or Out-of-Network* Hospital (The Copayment is waived if you are admitted)	Emergency Room Copayment*
- Emergency room physician's fee, surgery, laboratory and x-ray tests, MRI, CT Scan, medical supplies and drugs	You pay $0*
Use of a licensed hospital Urgent Care Facility in the Network	Urgent Care Facility Copayment
- Urgent Care Facility physician's fee, surgery, laboratory and x-ray tests, MRI, CT Scan, medical supplies and drugs	You pay $0
Ambulance Services – Network or Out-of-Network* Services Transport by ambulance must be Medically Necessary. .	You pay $0*

***Benefits are limited to the Maximum Allowable Benefit. If you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and charge.

Coverage Outline	Your Cost*
III. Outpatient Physical Rehabilitation Services	
Physical Therapy and Occupational Therapy and Speech Therapy (Up to a combined maximum of 60 therapy visits per Member, per Contract Year)	You pay $0
Cardiac Rehabilitation Visits	Specialty Visit Copayment
Chiropractic Care • Office Visits	
• Laboratory and x-ray tests furnished by a chiropractor	You pay $0
Early Intervention Services Available from birth to a covered child's third birthday.	Specialty Visit Copayment
IV. Home Care (in addition to the Preventative Care listed in subsection II above)	
Physician Services Medical exams and routine physical exams for babies, children and adults, medical treatments, surgery and anesthesia	Visit Copayment or Specialty Visit Copayment
Injections (including allergy injections)	You pay $0
Home Health Agency Services	
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	You pay $0
V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/Office Visits and Telemedicine Visits **Mental Health Visits -** Unlimited Medically Necessary visits **Substance Abuse Visits** (including detoxification and substance abuse rehabilitation) - Unlimited Medically Necessary visits	$20 Copayment each visit
Partial Hospitalization and Intensive Outpatient Treatment Programs **Mental Disorders -** Unlimited Medically Necessary care **Substance Abuse Conditions -** Unlimited Medically Necessary care for rehabilitation	You pay $0
Inpatient Care **Mental Disorders -** Unlimited Medically Necessary Inpatient days **Substance Abuse Conditions** (including detoxification and substance abuse rehabilitation) - Unlimited Medically Necessary Inpatient days	Inpatient Copayment per admission
Scheduled Ambulance Transport - Network or Out-of-Network* Services Transport by ambulance must be Medically Necessary.	You pay $0*

*Benefits are limited to the Maximum Allowable Benefit. If you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and charge.

Access Blue New England
Subscriber Certificate

For Employees of the Manchester School District

What You Need to Know about Your Group Managed Health Care Plan

IMPORTANT INFORMATION

THIS CERTIFICATE REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, THOSE CHANGES WILL BE INCORPORATED INTO YOUR CERTIFICATE.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the Customer Service number on your identification card or in this Certificate.

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.

Anthem Blue Cross and Blue Shield is located at
1155 Elm Street, Suite 200
Manchester, New Hampshire 03101-1505
Our toll-free telephone number is 1-800-870-3122

12630NH (7/15)

Welcome!

Anthem Blue Cross and Blue Shield (Anthem) welcomes you to the family of Members who have selected this managed health care plan to meet their health Benefit needs. Your membership is appreciated! Please contact Anthem with your questions, concerns or suggestions. Anthem's Customer Service Representatives are available during business hours to assist you. When you call or write, please provide the identification number listed on your identification card so that Anthem's representatives can assist you without delay.

Please call Customer Service at 1-800-870-3122.

Or, you can contact Anthem as follows:

	Mail to
Customer Service Inquiries, assistance, Benefit questions or claims status	Anthem Blue Cross and Blue Shield P.O. Box 660 North Haven, Connecticut 06473-0660
Appeals - Review of a Claim Denial	Anthem Blue Cross and Blue Shield P.O. Box 518 North Haven, Connecticut 06473-0518
Claims - Submission of claims for processing	Anthem Blue Cross and Blue Shield P.O. Box 533 North Haven, Connecticut 06473-0533
You can visit Anthem at	Anthem Blue Cross and Blue Shield 1155 Elm Street, Suite 200 Manchester, New Hampshire 03101-1505
How to Obtain Language Assistance Anthem is committed to communicating with Members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of Anthem's Customer Service Call Centers. Simply call Customer Service at 1-800-870-3122. A representative will be able to assist you. Translation of written materials about your Benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs. **Please visit Anthem's website at www.anthem.com.**	

Lisa M. Guertin
President and General Manager
New Hampshire

This product is administered by Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield (Anthem). Anthem is licensed in the State of New Hampshire as a third party administrator. Anthem is an independent licensee of the Blue Cross and Blue Shield Association.

Important: This is not an insured benefit plan. The Benefits described in this Certificate or any rider or amendments hereto are funded by the Group who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Your Group assumes responsibility for funding of claims.

A "Local Plan" is the affiliated New England Blue Cross and Blue Shield plan that administers written agreements made directly between the Local Plan and Network Providers in a Designated Network.

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SECTION 1 OVERVIEW – HOW YOUR PLAN WORKS

Please see Section 14 for definitions of specially capitalized words.

I. About This Certificate

This is your Subscriber Certificate. It describes a partnership between you, your physician, your Group and Anthem. You are entitled to the Benefits described in this Certificate. Certain rights and responsibilities are also described in this Certificate.

Your Cost Sharing Schedule is an important part of this Certificate. It lists your cost sharing amounts and certain Benefit limitations. Riders, endorsements or other amendments that describe additional Covered Services or limitations may also be issued to you. Please read your Certificate, Cost Sharing Schedule, riders, endorsements and amendments carefully, because they explain the terms of your coverage.

II. Your Primary Care Provider (PCP)

In this Certificate, your Primary Care Provider is called your PCP. Each Member must select a PCP at enrollment time. PCPs include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians.

To select your PCP, use the applicable Local Plan's provider directory, which Anthem makes available at enrollment time. For example, to select a New Hampshire PCP, use the New Hampshire directory. To select a Massachusetts PCP, use the Massachusetts directory. Or, call Customer Service for assistance. **The toll-free telephone number is 1-800-870-3122.**

Your PCP is a physician who becomes familiar with your medical history, may furnish your primary care and coordinates other health care services. It is recommended that you talk to your PCP *before* you receive health care services. If you need specialized care, your PCP may assist in coordinating your care by working with the hospitals, specialists and suppliers in the Network. Your PCP must authorize a Referral for Out-of-Network Services *in advance*. **Benefits for will be denied if you do not obtain your PCP's Referral as required. Please see Section 4 for more information.**

III. The Network

Providers who have network agreements directly with the same Local Plan make up a "Designated Network." The affiliated New England Blue Cross and Blue Shield plans share access to their Designated Networks by mutual agreement. For the purposes of this Certificate, all Designated Networks combined are referred to as "the Network." Also for the purposes of this Certificate, each provider in a Designated Networks is a Network Provider.

- **Network Providers in New Hampshire** are physicians, including Primary Care Providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians) and specialists, hospitals and other health care providers and facilities that have a network payment agreement directly with Anthem Health Plans of New Hampshire, Inc., (Anthem) to provide Covered Services to Members. New Hampshire Network Providers are listed in the New Hampshire Provider Directory. Since the printed directory is updated periodically, your directory book may not always be current at the time you need to arrange for Covered Services. **To locate the most up-to-date information about New Hampshire Network Providers, please go to Anthem's website, www.anthem.com. Or, you may contact Customer Service for assistance. The toll-free telephone number is 1-800-870-3122.**

- **Network Providers Outside New Hampshire** are physicians, including Primary Care Providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians), and specialists, hospitals and other health care providers and facilities *outside New Hampshire* that have a written payment agreement directly with one of the affiliated New England Local Plans. Network Providers are listed in each Local Plan's Network Directory, which is provided to Members by Anthem. Printed directories are updated periodically. Therefore, your directory book may not always be current at the time you need to arrange for Covered Services. Contact Customer Service for assistance in locating Network Providers in parts of the Service Area outside New Hampshire.

Network Providers are independent contractors who furnish Covered Services to Members. Anthem does not, nor does it intend to, engage in the performance or delivery of medical or hospital services or other types of health care.

Payment agreements may include financial incentives or risk sharing relationships related to provision of services or Referrals to other providers and disease management programs. Financial incentives for cost-effective care are consistent with generally recognized professional standards. If you have questions regarding such incentives or risk sharing relationships, please contact your provider or Anthem.

Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Subcontractors may include but are not limited to prescription drugs and Behavioral Health Care. Such subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, network management or customer service duties on Anthem's behalf.

The selection of a Network Provider or any other provider and the decision to receive or decline to receive health care services is the sole responsibility of the Member. Contracting arrangements between Network Providers and Anthem or between Network Providers and one of the Local Plans should not, in any case, be understood as a guarantee or warranty of the professional services of any provider or the availability of a particular provider.

Physicians, hospitals, facilities and other providers who are not Network Providers are Out-of -Network Providers.

IV. Group Coverage

You are covered under this Certificate as part of a Group. Your Group and Anthem determine eligibility rules. Your Group acts on your behalf by sending to Anthem the premium to maintain your coverage. By completing the enrollment process and enrolling in this health plan, you authorize your Group to make premium payments to Anthem on your behalf, and you agree to the terms of this Certificate. Provided that the required premium is paid on time, your coverage becomes effective on a date determined by your Group and by Anthem and as required by law.

V. Services Must be Medically Necessary

Each Covered Service that you receive must be Medically Necessary. Otherwise, no Benefits are available. This requirement applies to each Section of this Certificate and to the terms of any riders, endorsements or amendments. The definition of Medical Necessity is stated in Section 14.

Anthem may review services after they have been furnished in order to confirm that they were Medically Necessary. Network Providers are prohibited from billing you for care that is not Medically Necessary unless:

- You sign an agreement with the provider accepting financial responsibility for services, and/or
- The services are not Covered Services or are subject to a limitation or exclusion as described in this Certificate.

No Benefits are available for services that are not specifically described as Covered Services in this Certificate.

SECTION 2: COST SHARING TERMS

Please see Section 14 for definitions of other specially capitalized words.

Under this managed health care plan, you share the cost of certain Covered Services. Please see your Cost Sharing Schedule for specific cost sharing amounts.

If a Copayment, Coinsurance and/or Deductible amount is collected from a Member at the time of service and the amount exceeds the Member's Copayment, Coinsurance and/or Deductible liability as determined by Anthem, Network Providers who have a written payment agreement directly with Anthem are required to promptly refund to the Member the amount overpaid and will not apply the overpayment to outstanding balances due on unprocessed claims.

Depending on the plan chosen by your Group, you will find some or all of the following terms on your Cost Sharing Schedule:

I. Copayments

Copayments are fixed dollar amounts that you pay *each time* you receive certain Covered Services. The following is not a complete list of Copayment requirements that may apply under the plan chosen by your Group. Other Copayment requirements may be explained on your Cost Sharing Schedule or in riders or endorsements that amend this Certificate.

A **Visit Copayment** applies to Outpatient visits for medical/surgical care and Behavioral Health Care. Depending on the plan chosen by your Group, Copayment amounts may vary according to the type of provider you visit. For example, the Copayment for a visit to your Primary Care Provider (PCP) may be less than the Copayment for a visit to a specialist.

An **Outpatient Surgery Copayment** applies each time you have surgery or deliver a baby in an Outpatient surgical facility such as the Outpatient department of a hospital, an ambulatory surgical center or a Birthing Center. This Copayment does not apply to office surgery, Outpatient hemodialysis or surgery performed during an emergency room visit for Emergency Care.

The **Emergency Room Copayment** applies each time you use the emergency room at a hospital. This Copayment is waived if you are admitted to the hospital for Inpatient care directly from the emergency room. The **Urgent Care Facility Copayment** applies each time you visit a Network Urgent Care Facility for diagnosis, care and treatment of an illness or injury. The **Walk-In Center Copayment** applies each time you visit a Network Physician at a Network Walk-In Center in the Service Area for diagnosis, care and treatment of illness or injury. Please see Section 6, "Urgent and Emergency Care" for more information.

An **Inpatient Copayment** applies each time you are admitted as a bed patient to a Short Term General Hospital, Skilled Nursing Facility, Physical Rehabilitation Facility or to an eligible facility for Inpatient Behavioral Health Care.

Prescription Drug Copayments. Prescription Drug Copayments apply as shown on your Cost Sharing Schedule and as described in your Pharmacy Rider.

II. Inpatient and Outpatient Surgery Copayment Maximum

There is a limit to the amount of Inpatient Copayments and Outpatient Surgery Copayments (combined) that will apply to each Member's Covered Services each Contract Year. When the limit is met, no further Inpatient Copayments or Outpatient Surgery Copayments will apply to the Member's Covered Services for the remainder of the Contract Year.

There is a limit to the amount of Inpatient Copayments and Outpatient Surgery Copayments (combined) that will apply to the family's Covered Services each Contract Year. When the limit is met, no further Inpatient Copayments or Outpatient Surgery Copayments will apply to the family's Covered Services for the remainder of the Contract Year.

III. Other Out-of-Pocket Costs

In addition to the cost sharing amounts shown on your Cost Sharing Schedule, you are responsible for paying other costs, as follows:

A. Benefit-specific annual coverage limitations may apply to certain Covered Services, as allowed by law. Benefit-specific annual coverage limitations are stated on your Cost Sharing Schedule and in this Certificate. You are responsible for the cost of services that exceed an annual limitation.

There are no aggregate annual maximums under this health plan. Aggregate maximums are dollar limits that apply to all Covered Services per Member per Contract Year or Calendar Year.

B. Benefit-specific lifetime limitations apply to certain Covered Services or to a group of covered services, as allowed by law. Benefit-specific lifetime coverage limitations are stated on your Cost Sharing Schedule and in this Certificate. You are responsible for the cost of services that exceed a benefit-specific lifetime limitation.

There are no aggregate lifetime maximums under this health plan. Aggregate lifetime maximums are limits that apply to all Covered Services in a Member's lifetime.

C. Amounts That Exceed the Maximum Allowable Benefit. Benefits under this plan are limited to the Maximum Allowable Benefit. "Maximum Allowable Benefit" means the dollar amount available for a specific Covered Service. The Maximum Allowable Benefit is determined as stated in Section 14. As stated in this Certificate and your riders, endorsements or amendments, you may be responsible for paying the difference between the Maximum Allowable Benefit and the charge.

D. Noncovered or Excluded Services. You are responsible for paying the full cost of any service that is not described as a Covered Service in this Certificate. You are responsible for paying the full cost of any service that is excluded from coverage in this Certificate. This applies even if a physician or other Designated Provider prescribes, orders or furnishes the service and even if the services meets Anthem's definition of Medical Necessity.

IV. Out-of-Pocket Limit

Your Out-of-Pocket Limit is shown on your Cost Sharing Schedule. The Out-of-Pocket Limit includes all Copayments you pay during a Contract Year.

The Out-of-Pocket Limit does not include your premium, amounts over the Maximum Allowable Benefit or charges for noncovered services.

Once the Out-of- Pocket Limit is satisfied, you will not have to pay additional Copayments for the rest of the Contract Year.

SECTION 3: OPEN ACCESS TO NETWORK SERVICES

Please see Section 14 for definitions of specially capitalized words.

I. Open Access to Network Services

You have the freedom to seek Covered Services from any Network Provider in any Designated Network. You do not need a Referral from your PCP in order to access the Covered Services described in this Certificate, provided that your care is furnished by a Network Provider. This access rule applies to services such as, but not limited to: obstetrical and gynecological care, Behavioral Health Care and chiropractic care.

Please see Section 1, III, and "The Network" for more information about the Designated Networks shared by affiliated Blue Cross and Blue Shield plans.

Although you do not need a PCP Referral to access Network Services in any of the Designated Networks, you are encouraged to contact your PCP when you need health care services. By furnishing your primary care, your PCP will become familiar with your medical history and can better assist in coordinating your care when necessary. As explained in subsection III below, "Plan Approval for Specialized Care in the Network," your PCP may be required to contact Anthem or the Local Plan for Precertification *before* you receive certain Network Services. **Also, as explained in Section 4, you must obtain your PCP's Referral and Precertification from Anthem or from the Local Plan *before* you receive Out-of-Network Services.**

II. Selecting a PCP or Other Network Provider

Each Member must select a PCP in one of the Designated Networks. Even if you choose to seek Network Services from a provider who is not your PCP, you must select a PCP in one of the Designated Networks. The choice of PCP should be made at enrollment time. Different family members may have different health care needs. Therefore, each Member may select a different PCP. For example, you may choose a general practitioner PCP who is near your workplace. But for your child, you may choose a pediatrician PCP who is near your home. Family members may select PCPs in different Designated Networks. Indicate each family Member's PCP on your enrollment form. **For children, you may designate a Network Pediatrician PCP.**

Anthem provides directories that list PCPs and other Network Providers in each Designated Network. Printed directories are updated periodically. Therefore, your directory book may not always be current at the time you need to select a PCP or locate another Network Provider. For the most up-to-date information about **New Hampshire** Network Providers, please visit Anthem's website, www.anthem.com. Or, you may contact Customer Service for assistance. For the most up-to-date information about Network Providers located **outside New Hampshire**, contact Customer Service for assistance. **The toll-free telephone number is 1-800-870-3122.**

PCP Selection for Newborns - You should choose your newborn's PCP before your due date. You can notify Anthem of the selection by sending a completed enrollment form as soon as possible after your baby is born.

Changing a PCP - PCP changes can be made by calling Anthem's Customer Service Center or by writing to Anthem at the address listed in the Welcome Page of this Certificate. The change will become effective on the first day of the month after Anthem receives your call or letter. If you request a later effective date, we will honor your request. You can change your PCP for any reason. Anthem may inquire about your reason for changing a PCP because your information helps to maintain Network quality.

III. Plan Approval for Specialized Care in the Network

Anthem or the Local Plan must approve certain Covered Services *before* you receive them. This approval is called "Precertification." Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of

this Certificate including but not limited to, Copayment, Deductible, Coinsurance, the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

Most often, Network Providers, including PCPs, will Refer Members to other Network Providers for specialized care. Your Network Provider will obtain any required Precertification from Anthem or from the Local Plan for Network Services. Please see Section 4 for important Referral and Precertification rules that apply when you seek Out-of-Network Services.

<u>SECTION 4: ACCESS TO OUT-OF-NETWORK SERVICES</u>

Please see Section 14 for definitions of specially capitalized words.

I. Referrals and Plan Approval For Out-of-Network Services

In limited instances, your PCP or Network Provider may determine that your care cannot be furnished in the Network and that it is necessary for you to receive care from an Out-of-Network Provider. **Benefits are available for Out-of-Network Services only when the services are approved *in advance* by your PCP's Referral <u>and</u> *in advance* by Anthem or the Local Plan.** Your PCP is responsible for writing a Referral and for contacting Anthem or the Local Plan for Precertification. No Benefits will be available if you do not obtain your PCP's Referral *before* you receive Out-of-Network Services.

If Anthem or the Local Plan notifies you that Out-of-Network Services are not approved, and you decide to receive the services, no Benefits will be available and you will be responsible for the full cost of the care. No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services.

Except for Emergency Care as described in Section 6, you must contact your PCP to obtain a Referral *<u>before</u>* you receive Out-of-Network Services, even if you are temporarily outside the Service Area for a definite period of time (such as students, vacationers and business travelers). Your PCP will contact Anthem or the Local Plan for any required Precertification of the Out-of-Network Care. No Benefits will be Precertified or available for elective Inpatient or Outpatient care that can be safely delayed until you return to the Service Area or for care that a reasonable person would anticipate before leaving the Service Area. No Benefits are available for routine medical exams, immunizations, routine gynecological exams, diagnostic tests related to routine care, other preventive care or any other care that can be safely delayed until you return to the Service Area for Network Services. School infirmary facility or infirmary room charges are not covered under any portion of this Certificate.

Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible, Coinsurance requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

Benefits are limited to the Maximum Allowable Benefit. If you receive services from an Out-of-Network Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and the charge.

Please see Section 7, V, "Behavioral Health Care" for complete information about Preauthorization of Out-of-Network services for Mental Disorders and Substance Abuse Conditions.

II. Benefits are Not Available for Some Out-of-Network Services

The following Covered Services must be furnished by a Network Provider. Out-of-Network Services are not covered, even if you obtain a Referral from your PCP or other Network Provider:

- Routine vision. Please see Section 7, II, A, "routine vision exams." Covered Services must be furnished by a Network Provider. Otherwise, no Benefits are available.

- Certain Dental Services. Please see Section 7, VI, A, "Dental Services." As stated in that subsection, certain Dental Services are covered only when furnished by a Network Provider. Otherwise, no Benefits are available.

- Benefits are available for *routine* maternity care furnished by a *Network* New Hampshire Certified Midwife (NHCM) who is certified under New Hampshire law. Please see Section 7, II, B, "Maternity care."

- Out-of-Network Benefits are not available. Services furnished outside New Hampshire are covered only if all of the terms of Section 7, II, B are met, including NHCM certification under New Hampshire law.

- Chiropractic Care. Please see Section 7, III, "Chiropractic Care." Covered chiropractic services must be furnished by a Network Chiropractor, unless otherwise stated in an amendment to this Certificate. No Benefits are available for Out-of-Network Chiropractic Care.

- Diabetes management programs. Please see Section 7, II, A, "diabetes management programs." Covered Services must be furnished by a Network Diabetes Education Provider. Otherwise, no Benefits are available.

- Riders, endorsements or amendments to this Certificate may describe other services that are not covered when furnished by an Out-of-Network Provider. For example, under your Pharmacy Rider, Benefits are available only when Covered Services are furnished by a Network Pharmacy.

SECTION 5: ABOUT MANAGED CARE

Please see Section 14 for definitions of specially capitalized words.

This is a Managed Health Care plan. This means that when you receive certain Covered Services, Anthem (or a designated administrator) or the Local Plan works with you and your health care providers to determine that your Covered Services are Medically Necessary. The definition of Medical Necessity is stated in Section 14.

A Member's right to Benefits for Covered Services provided under this Certificate is subject to certain health care management policies or guidelines and limitations, including, but not limited to, Anthem's medical policy and guidelines for Precertification (including Anthem's Concurrent Review process). Health care management guidelines, their purposes, requirements and effects on Benefits, are described in this Section and throughout this Certificate. Failure to follow the health care management guidelines and procedures for obtaining Covered Services will result in reduction or denial of Benefits, as stated in this Certificate and any riders, endorsements or amendments that are part of this Certificate.

"Precertification" is the process used by Anthem to review services proposed by your Designated Provider to determine if the service meets Anthem's definition of Medical Necessity, as stated in Section 14 of this Certificate. Your provider's orders and/or Anthem's Precertification does not guarantee coverage for or the payment of the service or procedure reviewed. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible, Coinsurance requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

I. Your Role

You play an important role in this managed health care plan. As a Member, you should become familiar with and follow plan rules. These are described in Sections 1 through 6 of this Certificate. Knowing and following plan rules is the best way for you to enjoy all of the advantages of this coverage. For example, Section 3 explains that you need to select a PCP and you need to contact your PCP or Network Provider *before* you receive health care services. **Please remember that *you* are responsible for obtaining your PCP's written Referral *before* you receive Out-of-Network Services.**

Your suggestions about improving the plan are important to Anthem. Please contact Customer Service to let Anthem know about your suggestions. **The toll-free telephone number is 1-800-870-3122.**

You can appeal any decision made by Anthem about your coverage. Please see Section 11 for information about how to inform Anthem about your suggestions or to use the appeal procedure.

II. The Role of Network Providers

Your Network Providers work together to make sure that you have access to the health care services that you need. Your Network Provider is responsible to oversee and coordinate your health care services.

Most often, your Network Provider will provide your routine or urgent care directly. If your Network Provider determines that you require specialized care that falls outside his or her clinical expertise or services offered, your Network Provider will refer you to another provider. With few exceptions, you will be referred to a provider in the Network.

Your Network Provider will contact Anthem or the Local Plan as appropriate for any required Precertification for your Network Services. For example, if your Network Provider admits you to a hospital for Inpatient care, your Network Provider will let Anthem or the Local Plan know about the Referral and will provide Anthem or the Local Plan with any

clinical information that may be required to review the Referral. Your PCP will also contact Anthem or the appropriate Local Plan to provide the clinical information required to review a Referral to an Out-of-Network Provider.

III. The Role of Anthem and the Local Plan

As the administrator of Benefits under this health plan, Anthem's Medical Director and Medical Management division (and the Medical Directors and medical management divisions of Local Plans) play an important role in the management of your Benefits. Some examples are:

A. Referral review and Precertification - Anthem and Local Plans require that Network Providers must obtain Precertification from the appropriate plan before you receive Inpatient care and before you receive certain Outpatient services. Precertification of any Referral for Out-of-Network Services is required by Anthem and by the Local Plans. Emergency admissions must be reported to Anthem within 48 hours so that we can conduct a Precertification review. If you have any questions regarding Managed Care guidelines or to determine which services require Precertification, please call Customer Service for assistance **The toll-free telephone number is 1-800-870-3122.** Or, you may refer to our website at: www.anthem.com.

"Precertification" refers to the process used by Anthem to review your health care services to determine if the service is Medically Necessary, is delivered in the most appropriate health care setting. Precertification does not guarantee coverage for or the payment of the service or procedure reviewed. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible, Coinsurance requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate. Whenever Anthem or the Local Plan reviews a Network Provider's Referral or any Precertification request, the appropriate Medical Director may discuss the services with your Network Provider or with another provider and may ask for medical information about you and the proposed services. A Medical Director may determine that Benefits are available only if you receive services from a Network Provider, a Contracting Provider or from a Designated Provider that is, in the opinion of the Medical Director, most appropriate for your care. The decision to receive or decline to receive health care services is your sole responsibility, regardless of the decision made regarding reimbursement.

B. Prior Approval. At your physician's request, Anthem will review proposed services to determine if the service is a Covered Service that meets Anthem's definition of Medical Necessity as stated in Section 14 of this Certificate. For example, if your physician proposes Outpatient surgery that may be considered a noncovered cosmetic or dental procedure, he or she may submit clinical information for review *before* you receive the service. To make coverage determinations, Anthem refers to managed care guidelines, internal policies including, but not limited to medical policies and the terms of this Certificate. *The prior approval process does not satisfy Precertification requirements*. If your proposed service requires Precertification, please refer to Section 4 for complete information.

C. Determinations about Medical Necessity. Anthem makes determinations about Medical Necessity based on the definition found in Section 14. Anthem's medical policy assists in Anthem's determinations regarding Medical Necessity and other related issues. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding
Medical Necessity. Please see Section 11 for complete information.

D. Determinations about Experimental/Investigational Services. Anthem reviews services that may be Experimental/Investigational based on the terms of Section 8, II, "Experimental/Investigational Services. Anthem's medical policy assists in Anthem's review regarding Experimental/Investigational Services and other issues. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Experimental/Investigational Services. Please see Section 11 for complete information.

E. 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 physicians from various medical specialties including Anthem's Medical Directors, physicians in academic medicine and physicians 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.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding coverage for new technologies. Please see Section 11 for complete information.

F. Health Plan Individual Case Management. Anthem's 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. Anthem's programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Anthem's 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, Anthem 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 providers and other providers.

In addition, Anthem 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 may provide benefits for alternate care that is not listed as a Covered Service. Anthem may also extend Covered Services beyond the benefit limits stated in this Certificate. Anthem will make decisions case-by-case, if in Anthem's discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Anthem to provide the same benefits again to you or to any other Member. Anthem reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, Anthem will notify you or your authorized representative in writing. Members who disagree with Anthem's determination may utilize the appeal procedure described in Section 11.

IV. Important notes about this Section

Your PCP's Referral, Designated Provider's orders, Anthem's Precertification or Prior Approval does not guarantee Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible, Coinsurance requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

Anthem's Medical Director or Medical Management division takes into consideration the recommendations of the Member's physician and clinical information when making decisions about Precertification requests, Prior Approval requests, Medical Necessity, Experimental/Investigational Services and new technologies. When appropriate to review a

proposed service, Anthem's Medical Director or Medical Management division considers published peer-review medical literature about the service, including the opinion of experts in the relevant specialty. At times, Anthem may consult with experts in the specialty. Anthem may also review determinations or recommendations of nationally

recognized public and private organizations that review the medical effectiveness of health care services and technology.

Anthem 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 Anthem 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 Members.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management). In addition, Anthem may select certain qualifying providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. Anthem may also exempt your claim from medical review if certain conditions apply. Just because Anthem exempts a process, provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other provider, claim or Member. Anthem may stop or modify any such exemption with or without advance notice.

Anthem 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 Anthem 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 Members.

SECTION 6: URGENT AND EMERGENCY CARE

Please see Section 14 for definitions of specially capitalized words.

I. Urgent Care

Whenever possible, contact a Network Physician for direction *before* you receive urgent medical care. Examples of conditions that may require urgent care are: sprain, sore throat, rash, earache, minor wound, moderate fever or abdominal or muscle pain.

Please note: You will have lower out-of-pocket expenses if you to seek urgent care from your PCP or Network obstetrical/gynecological specialist as an alternative to use of a hospital emergency room or urgent care facility. If it is not possible or safe for you to delay care until you can visit your PCP or Network obstetrical/gynecological specialist, you will have lower out-of-pocket expenses if you visit a Network Physician at a Network Walk-In Center as an alternative to use of a hospital emergency room or urgent care facility. Please see page 1 of your Cost Sharing Schedule to compare the Visit Copayment, Walk-In Center Copayment, Urgent Care Facility Copayment and Emergency Room Copayment.

You do not need to obtain your PCP's Referral before you visit a Network Walk-In Center or Network Urgent Care Facility for urgent care.

II. Emergency Care

It may not always be possible or safe to delay treatment long enough to consult with your Network Physician or Anthem before you seek care. In a severe emergency, go to the nearest emergency facility immediately for Emergency Care. Call 911 for assistance if necessary.

Emergency Care furnished in a licensed hospital emergency room is covered. Emergency Care means Covered Services you receive due to the sudden onset of a serious condition. A serious condition is a medical, psychological or substance abuse condition that manifests itself by symptoms of such severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect that immediate medical attention is needed to prevent any of the following:

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

Examples of conditions or symptoms that may require Emergency Care are suspected heart attack or stroke, a broken bone, uncontrolled bleeding, unconsciousness (including as a result of drug overdose or alcohol poisoning) or you are at serious risk of harming yourself or another person.

Emergency Care includes all of the Covered Services typically provided in a licensed hospital emergency room including, but not limited to ancillary services to evaluate a person's condition and further medical examination and treatment as required to stabilize the person.

III. Emergency Room Visits for Emergency Care

Benefits are available for Emergency Care in any licensed hospital emergency room, provided that at least one of the following criteria is met:

- Your condition meets the definition of Emergency Care as stated in II (above), or

- The symptoms that caused you to seek care in a hospital emergency room would be judged by a reasonable person to require Emergency Care as defined in II (above), or

- You obtain your PCP's Referral or approval from your Network Obstetrician/Gynecologist *in advance.*

No approval given by Anthem or a Network Provider for Emergency Care will be rescinded or modified after the care is furnished, provided that your coverage is in effect on the date you receive the care.

Your share of the cost for use of the emergency room is shown on your Cost Sharing Schedule. Any Emergency Room Copayment is waived if you are admitted to the hospital as a bed patient (Inpatient) directly from the emergency room.

Please note: You will have lower out-of-pocket expenses if you to seek urgent care from your PCP or Network obstetrical/gynecological specialist as an alternative to use of a hospital emergency room or urgent care facility. If it is not possible or safe for you to delay care until you can visit your PCP or Network obstetrical/gynecological specialist, you will have lower out-of-pocket expenses if you visit a Network Physician at a Network Walk-In Center as an alternative to use of a hospital emergency room or urgent care facility. Please see page 1 of your Cost Sharing Schedule to compare the Visit Copayment, Walk-In Center Copayment, Urgent Care Facility Copayment and Emergency Room Copayment.

Please note: If you receive Out-of-Network Services in an emergency room, you may be required to pay amounts that exceed Anthem's Maximum Allowable Benefit.

You do not need to obtain your PCP's Referral before you visit a licensed hospital emergency room for Emergency Care or a Network Walk-In Center or Network Urgent Care Facility for urgent care.

IV. Inpatient Admissions to a Hospital for Emergency Care

Your share of the cost for Inpatient Services is shown on part I of your Cost Sharing Schedule.

A. Medical/surgical admissions for Emergency Care - Benefits are available for an Inpatient admission for medical/surgical Emergency Care, provided that Inpatient care is Medically Necessary and your condition meets the definition of Emergency Care as stated in II (above).

If it is not safe or possible to delay care until you can contact your Network Provider *in advance* for direction, you (or someone acting for you) must do one of the following:

- Notify your Network Provider after you are admitted, **or**

- Notify Anthem after you are admitted by calling **1-800-531-4450**.

Notice to your Network Provider or to Anthem must be made within 48 hours after you are admitted or on the next business day after you are admitted, whichever is later.

If you fail to make notice as required and Anthem later determines that the care was not Emergency Care (as defined in II above), did not meet the definition of Medical Necessity stated in Section 14 or was otherwise a noncovered service, no Benefits will be available and you will be responsible for the full cost of the care.

If you are unable to call within 48 hours, Anthem's Medical Director will determine if your circumstances prevented timely notification. Anthem determines whether or not Emergency Care conditions are met by reviewing your admission records.

Please see Sections 3 and 4 for information about access to planned or scheduled Network Services and Out-of-Network Services. Please remember that Out-of-Network Services must be approved *in advance* by your PCP and by Anthem. Otherwise, no Benefits are available for the Out-of-Network Services.

Important Note: You do not need to contact Anthem, or your Network Provider or your PCP within 48 hours of a maternity admission, provided that your prenatal care is furnished by a Network Provider who specializes in maternity care and you are admitted to a hospital in the Network. *Out-of-Network prenatal care must be authorized in advance by your PCP's Referral and Anthem's Precertification.* Otherwise, no Benefits are available for the prenatal care or for the maternity admission. Please see Section 4 for complete information about access to Out-of-Network Services.

Please note: If you receive Inpatient Services at an Out-of-Network Hospital, you may be required to pay amounts that exceed Anthem's Maximum Allowable Benefit.

B. Behavioral Health admissions for Emergency Care. Benefits are available for Inpatient admissions for Behavioral Health Emergency Care, provided that Inpatient care is Medically Necessary and your condition meets the definition of Emergency Care as stated in II (above).

If you are admitted to a hospital as a bed patient for Inpatient Emergency Behavioral Health Care, you (or someone acting for you) **must contact Anthem for Preauthorization within 48 hours** (or on the next business day, whichever is later). Please call **1-800-228-5975** for Preauthorization.

If you fail to make notice as required and Anthem later determines that the care was not Emergency Care as defined in II above, did not meet the definition of Medical Necessity stated in Section 14 or was otherwise a noncovered service, no Benefits will be available and you will be responsible for the full cost of the care.

If you are unable to call within 48 hours, Anthem will determine if your circumstances prevented timely notification. Anthem determines whether or not Emergency Care conditions are met by reviewing your admission records.

Please see Section 7, V, "Behavioral Health Care (Mental Health and Substance Abuse Care)" for information about Preauthorization of non-emergency Inpatient admissions for Behavioral Health Care. Scheduled Inpatient admissions must be approved *in advance* by Anthem. Otherwise, Benefits may be reduced as described in Section 7, V.

Please note: If you receive Inpatient Services at an Out-of-Network Hospital, you may be required to pay amounts that exceed Anthem's Maximum Allowable Benefit.

V. Limitations

In addition to the limitations and exclusions listed in Section 7, VI and in Section 8, the following limitations apply specifically to Emergency Care:

A. "Follow-up" care is any related Covered Service that you receive after your initial emergency room visit. To be eligible for Benefits for medical/surgical conditions, your follow-up care must be furnished by a Network Provider. Otherwise, no Benefits are available for the follow-up care. For Mental Disorders or Substance Abuse Conditions, the plan rules stated in Section 7, V apply to follow-up care.

B. When determining whether or not your services meet the definitions of Emergency Care in this Section, Anthem will consider not only the outcome of your Outpatient visit or Inpatient admission, but also the symptoms that caused you to seek the care. To make this determination, Anthem reserves the right to review medical records after you have received your services.

C. Emergency Care does not include routine care. Routine care includes, but is not limited to, routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, immunizations or preventive care. Emergency Care does not include any service related to or resulting from routine care.

D. Emergency Care does not include elective care. Elective care is care that can be delayed until you can contact your Network Physician or Anthem for direction *in advance*. Examples of elective care include, but are not limited to: scheduled Inpatient admissions or scheduled Outpatient care. Emergency Care does not include any service related to or resulting from elective care.

E. Complications of noncovered services. No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services, even if the care meets Anthem's definitions of Emergency Care and/or Medical Necessity.

F. If you are admitted as a bed-patient to an Out-of-Network Hospital for Emergency Care, eligible Benefits are provided only until Anthem and your Network Physician determine that your condition permits your transfer to a Network Hospital. The mode of transportation will be selected by Anthem and the cost of the selected transportation will be covered.

SECTION 7: COVERED SERVICES

Please see Section 14 for definitions of specially capitalized words.

This Section describes Covered Services for which Anthem provides Benefits. All Covered Services must be prescribed or furnished by a Designated Provider according to the plan guidelines stated in this Certificate. Preventive Care services are listed in subsection II (below). All other Covered Services must be Medically Necessary for the diagnosis and treatment of disease, illness, injury, or for maternity care. Otherwise, no Benefits are available. The Covered Services described in this Section are available for treatment of the diseases and ailments caused by obesity and morbid obesity, as required by New Hampshire law.

Please remember the plan guidelines explained in Sections 1 through 6. Some important reminders are:

- Members are entitled to the Covered Services described in this Section. All Benefits are subject to the exclusions, conditions and limitations, terms and provisions described in Section 8, "Limitations and Exclusions," and elsewhere in this Certificate and any amendments to this Certificate.

- To receive maximum Benefits for Covered Services, you must follow the terms of the Certificate, including, when applicable, receipt of care from a Network Provider and obtaining any required Precertification.

- Benefits for Covered Services are based on the Maximum Allowable Benefit for such services. Deductible amounts are limited to the Maximum Allowable Benefit. No Benefits are available for amounts that exceed Anthem's Maximum Allowable Benefit.

- Anthem's payment for Covered Services will be limited by any Copayment, Deductible, Coinsurance or annual or lifetime Benefit limit applicable to your plan. Such limitations are stated on your Cost Sharing Schedule, this Certificate and in any amendments to this Certificate.

- Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate.

- 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.

- Anthem makes determinations about Referrals, Precertification, Medical Necessity, Experimental / Investigational Services and new technology based on the terms of this Certificate, including, but not limited to the definition of Medical Necessity. The definition of Medical Necessity is stated in Section 14. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. Please see Section 11 for complete information.

Please note:

- This Section often refers to your Cost Sharing Schedule. *Your cost sharing amounts and important limitations are shown on the Cost Sharing Schedule.*
- With few exceptions, Benefits are available only when your Network Provider furnishes Covered Services. Exceptions are stated in Section 4. Otherwise, no Benefits are available.
- Out-of-Network care must be approved by your PCP and by Anthem or by the appropriate Local Plan in advance. If Anthem or the Local Plan notifies you that Out-of-Network services are not approved and you decide to receive the services, no Benefits will be available. You will be responsible for the full cost of the care.

I. Inpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Inpatient medical/surgical admissions. This includes maternity admissions. Coverage includes the following:

A. Care in a Short Term General Hospital - semi-private room and board, nursing care, pharmacy services and supplies, laboratory and x-ray tests, operating room charges, delivery room and nursery charges, physical, occupational and speech therapy typically provided in a Short Term General Hospital while you are a bed patient. Custodial Care is not covered. Please see Section 8, II for a definition of "Custodial Care."

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours except when authorization is required for use of certain providers or facilities, or to reduce your out-of-pocket costs.

Also, under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

B. Care in a Skilled Nursing Facility or Physical Rehabilitation Facility - semi-private room and board, nursing and ancillary services typically provided in a Skilled Nursing or Physical Rehabilitation Facility while you are a bed patient (Inpatient). *Benefits are limited as shown on your Cost Sharing Schedule*. When counting the number of Inpatient days, the day of admission is counted but the day of discharge is not. Custodial Care is not covered. Please see Section 8, II for a definition of "Custodial Care."

C. Inpatient Physician and Professional Services - physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests. Benefits for Inpatient medical care are limited to daily care furnished by the attending physician, unless another physician's services are Medically Necessary, as determined by your Network Physician and Anthem or the appropriate Local Plan. For Skilled Nursing or Physical Rehabilitation Facility admissions, *Benefits are limited as shown on your Cost Sharing Schedule*. Custodial Care is not covered. Please see Section 8, II for a definition of "Custodial Care."

Please see subsection V, "Behavioral Health Care (Mental Health and Substance Abuse Care" and subsection VI, "Important Information about Other Covered Services" for related information about Inpatient services. Also, see Section 8 for important Limitations and Exclusions that may apply to Inpatient Services.

II. Outpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Outpatient medical/surgical care. Coverage includes the following:

A. Preventive Care. In general, the term "Preventive Care" under this Certificate refers to medical care for adults and children with no current symptoms or prior history of a medical condition associated with the care. For Members who have current symptoms or have been diagnosed with a medical condition, services associated with the symptoms or diagnoses are not Preventive Care. Some exceptions to this definition are listed in this subsection but otherwise, services for the diagnosis or treatment of an illness, injury or medical condition are covered under other applicable sections of this Certificate. Whether or not a service is Preventive Care, Covered Services are subject to

the cost sharing requirements specified on your Cost Sharing Schedule. For the purposes of this subsection, Preventive Care services are:

1. **Preventive care as required by law.** The following preventive services are covered up to 100% of Anthem's Maximum Allowable Benefit as required by law. The list may change from time to time. Please call Customer Service for the most up-to-date information about preventive health services that are covered in full as required by law. Or, you may visit Anthem's website at www.anthem.com for information.

   - Immunizations for babies, children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

   - Routine physical exams for babies, children and adults including one annual gynecological exam

   - Cancer screening such as routine colonoscopy and routine sigmoidoscopy

   - Services with an "A" or "B" rating from the United States Preventive Services Task Force including, but not limited to screenings for:
     Breast cancer (such as but not limited to routine mammograms)
     Cervical cancer (such as but not limited to pap smears)
     Colorectal cancer
     High Blood Pressure
     Type 2 diabetes mellitus
     Cholesterol
     Child and adult obesity

   - Genetic counseling

   - Lead screening

   - Nutrition counseling by a Network Nutrition Counselor practicing independently or as part of a physician practice or Outpatient hospital clinic. Coverage includes but is not limited to nutrition counseling for treatment of eating disorders.

     Out-of-Network nutrition counseling is not covered.

     Please note: Other nutrition counseling Benefits are available when furnished by a Network Home Health Agency. Please see subsection IV, "Home Care" for more information.

     Benefits are available for weight management counseling provided during covered nutrition counseling visits or as part of a covered diabetes management program (see 8, "diabetes management programs" below). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Certificate. However, Benefits are available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

     For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see subsection VI, G, 4, "Surgery for conditions caused by obesity."

     No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

- Additional Preventive Care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration (HRSA), including:

  - Contraceptive services for women. As required by law, contraceptive services are covered at no cost for women with reproductive capacity. This benefit includes at least one form of contraception in each of the contraceptive methods identified for women by the U.S. Food and Drug Administration (FDA). FDA-identified methods include, but are not limited to barrier methods, hormonal methods, implanted devices and sterilization procedures. Education and counseling, Outpatient consultations, examinations and medical services related to the use of contraceptive methods are also covered at no cost under this section.

    FDA-approved contraceptive Prescription Drugs and devices for women are covered at no cost under this section. This benefit includes Generic and single-source Brand Drugs, injectable contraceptives and patches, diaphragms, intra uterine devices (IUDs), and implants. Multi-source Brand Drugs and devices are covered at no cost under this section only if your physician determines that a Multi-source Brand contraceptive is medically necessary and writes, "Dispense as Written" or "Do not Substitute" on your Prescription. Otherwise, Multi-source Brand Drugs and devices will be covered under your Pharmacy Rider or under subsection B **"**Medical/Surgical Care in a Physician's Office."

    Over-the-counter contraceptive methods identified for women by the FDA are covered at no cost under this section when obtained with a Prescription from your physician.

  - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

  - Screenings and/or counseling, where applicable, for gestational diabetes, human papilloma virus (HPV), sexually transmitted infections (STIs), human immune-deficiency virus (HIV), and interpersonal and domestic violence.

  - Annual gynecological exams.

  - Office visits for routine prenatal care.

- Preventive care services for tobacco cessation as recommended by the United States Preventive Services Task Force including:

  - Counseling
  - Prescription Drugs
  - Nicotine replacement therapy products when prescribed by a physician, including over the counter (OTC) nicotine gum, lozenges and patches. By law, some of these products may be subject to age limitations.

  Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.

- 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:

  - Aspirin
  - Folic acid supplement
  - Vitamin D supplement
  - Iron supplement
  - Bowel preparations

- Other Preventive Care and screenings that must be covered under this section by law.

You may call Anthem's Customer 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.govand http://www.cdc.gov/vaccines/acip/index.html.

The following Preventive Care services are subject to the cost sharing requirements specified on your Cost Sharing Schedule:

2. Routine hearing exams for Members with no current symptoms or prior history of a hearing illness, injury or the need for hearing aids for hearing correction. Please see subsection VI "Important Information About Other Covered Services," B "Hearing Services" for information about services for ear disease or injury.

3. Travel and rabies immunizations

4. Routine vision exams by an optometrist or ophthalmologist to determine the need for vision correction. *Benefits may be limited, as shown on your Cost Sharing Schedule* Please see subsection VI "Important Information About Other Covered Services," H "Vision Services" for information about services for eye disease or injury.

   Eyewear. Benefits are available for prescription eyewear (frames, lenses and contact lenses). Anthem pays the allowed amount shown on your Cost Sharing Schedule. You are responsible for paying the difference between the allowed amount and the charge

   Covered Services must be prescribed by an optometrist or ophthalmologist *for vision correction* and must be furnished by a licensed eyewear provider.

   - After Anthem has paid the allowed amount for Covered Services every other Contract Year as shown on your Cost Sharing Schedule, no additional Benefits are available until the next eligible Contract Year, even if your frames, lenses or contact lenses are lost, stolen or damaged or if your prescription changes.

   - If the Benefit is not used every other Contract Year, the remainder is not redeemable for cash and cannot be carried forward to the next eligible Contract Year.

   - Coverage is limited to eyewear prescribed for vision correction. No Benefits are available for nonprescription eyeglasses, lenses or contact lenses. No Benefits are available for recreational or vocational glasses, goggles or other protective/safety eyewear or for glasses or lenses required for employment. When frames are purchased separate from lenses, Anthem may require a copy of the lens prescription in order to determine Benefit eligibility for the frames.

   - No Benefits are available for magnification vision aids.

   Note: If the lens of your eye has been surgically removed or is congenitally absent, please see subsection IV, E "Durable Medical Equipment and Medical Supplies" for Benefit information.

   No Benefits are available under any portion of this Certificate for eyewear, except as stated above and in subsection IV, E "Durable Medical Equipment and Medical Supplies."

5. Diabetes Management Programs. Covered Services must be ordered by a physician and furnished by a Network Diabetes Education Provider. No Benefits are available for Out-of-Network Services. Covered Services include:

   - Individual counseling visits,

   - Group education programs and fees required to enroll in an approved group education program, and

- External insulin pump education is covered for Members whose external insulin pump has been approved by Anthem. The Diabetes Education Provider must be pump-certified. Please see subsection IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about coverage for external insulin pumps.

In addition to the limitations and exclusions listed in Section 8 of this Certificate, the following limitations apply specifically to diabetes management services:

- No Benefits are available for services furnished by a provider who is not a Network Diabetes Education Provider.

- Insulin, diabetic medications, blood glucose monitors external insulin pumps and diabetic supplies are not covered under this subsection. Please see subsection IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about diabetic supplies. **Insulin, diabetic medications and diabetic supplies are also covered under your Pharmacy Rider when Covered Services are purchased at a pharmacy.**

Benefits are available for weight management counseling provided as part of a covered diabetes management program or during covered nutrition counseling visits (see 1 above). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Certificate. However, Benefits are available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see subsection VI "Important Information About Other Covered Services," G "Surgery," 4 "Surgery for conditions caused by obesity."

No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

B. Medical/Surgical Care in a Physician's Office. In addition to Preventive Care commonly provided in a physician's office (see A, above), the following services are covered:

1. Medical exams, consultations, office surgery and anesthesia, injections (including allergy injections), medical treatments (including allergy treatments) furnished in a physician's office, including services furnished at a Walk-In Center.

2. Laboratory and x-ray tests (including allergy testing and ultrasound)

3. CT Scan, MRI, chemotherapy

4. Medical supplies and drugs administered in an office. Benefits are available for covered prescription medications, injectable drugs, radioactive materials, dressings and casts administered or applied in a physician's office for the prevention of disease, illness or injury or for therapeutic purposes. No Benefits are available for fertility hormones or fertility drugs.

   Hormones, insulin and prescription drugs purchased at a physician's office for use outside the office are not covered under any portion of this Certificate. Please see your Pharmacy Rider for coverage information. Medical equipment, supplies and prosthetics purchased for use outside a physician's office are not covered under this subsection. Please see subsection IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics" for coverage information.

5. Maternity care. *Total maternity care includes the provider's fees for prenatal visits, delivery, Inpatient medical care and postpartum visits.* Most often, your provider bills all of these fees together in one charge

for delivery of a baby and the Benefit includes all of the services combined. The Benefit is available according to the coverage in effect on the date of delivery. Note: If a provider furnishes *only* prenatal care or the delivery, or postpartum care, Benefits are available according to the coverage in effect on the date you receive the care.

Covered Services may be furnished by any Network Provider acting within the scope of his or her license. For example, Covered services may be furnished by *a Network Obstetrician/Gynecologist, a Network Advanced Practice Registered Nurse (APRN) obstetrician*/gynecologist or a Network New Hampshire Certified Midwife (NHCM).

Benefits are available for *routine* maternity care furnished by a Network New Hampshire Certified Midwife (NHCM), provided that the Network NHCM is certified under New Hampshire law and acting within an NHCM's scope of practice as defined in New Hampshire law. Coverage includes, but is not limited to home deliveries. Out-of-Network NHCM services are not covered.

Benefits are available for urgent and emergency care as described in Section 6 and all of the Medically Necessary Covered Services described in this Section with respect to pregnancy, tests and surgery related to pregnancy, complications of pregnancy, termination of pregnancy or miscarriage. Ultrasounds in pregnancy are covered only when Medically Necessary. Please see subsection VI, C, "Infertility Diagnostic Services" for important restrictions regarding infertility treatment.

Out-of-Network Services are not covered unless the services are authorized *in advance* by the Member's PCP and Precertified *in advance* by Anthem or the appropriate Local Plan, as explained in Section 4.

Benefits are not available for maternity care or related care outside the Service Area when:

- The delivery occurs outside the Service Area within 30 days of the baby's due date, as established by the Network Provider who furnishes the mother's prenatal care, and

- The care is not approved by the mother's PCP Referral *before* the mother leaves the Service Area. Anthem or the appropriate Local Plan must also approve Out-of-Network care *before* the mother leaves the Service Area.

Please see Section 4, I, "Referrals and Plan Approval For Out-of-Network Services," for important limitations on access to Out-of-Network Services.

C. Outpatient Facility Care: in the Outpatient Department of a Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center. In addition to Preventive Care commonly provided in an Outpatient facility (see A, above), Benefits are available for Medically Necessary facility and professional services in the Outpatient department of a Short Term General Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center. Coverage includes the following:

1. Medical exams and consultations by a physician

2. Operating room for surgery or delivery of a baby

3. Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy

4. Hemodialysis, chemotherapy, radiation therapy, infusion therapy

5. CT Scan, MRI

6. Medical supplies, drugs, other ancillaries, facility charges, including but not limited to facility charges for observation. Observation is a period of up to 24 hours during which your condition is monitored to determine if Inpatient care is Medically Necessary.

7. Laboratory and x-ray tests (including ultrasounds)

Please note that Ambulatory Surgical Centers and Birthing Centers must have a written payment agreement with Anthem or with their local Blue Cross and Blue Shield plan. Otherwise, the center is not a Designated Provider and no Benefits will be available for services provided to you in the facility. This exclusion applies even if the care is prescribed by a Designated Provider and meets Anthem's definition of Medical Necessity.

Also, see subsection III, "Outpatient Physical Rehabilitation Services".

D. Emergency Room Visits for Emergency Care. Covered Services are shown on your Cost Sharing Schedule. Please see Section 6 for important guidelines about Emergency Care.

E. Ambulance Services. Benefits are available for Medically Necessary ambulance transport to a medical facility for Emergency Care. For example, coverage includes ambulance transport to a hospital from the scene of an accident or to a hospital from your home due to symptoms of a heart attack.

If you receive Out-of-Network ambulance Services, you may be responsible for the difference between the Maximum Allowable Benefit and the provider's charge.

In addition to the limitations and Exclusions listed in Section 8, the following limitations apply to Ambulance Services:

- Nonemergency ambulance transport is not covered. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No Benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi.

- No Benefits are provided for ambulance transportation to or from medical appointments. No Benefits are provided for non-ambulance transportation to or from medical appointments.

- Benefits are provided for air ambulance transport furnished by an air ambulance service to take you to a hospital only when it is Medically Necessary for you to be transported by air rather than ground ambulance. If Anthem determines that air ambulance transportation was not Medically Necessary, and that ground ambulance would have been Medically Necessary, Anthem will provide the Maximum Allowable Benefit for a ground ambulance. In this case, you pay the difference between the Maximum Allowable Benefit and the air ambulance charge.

F. Telemedicine Services. Telemedicine is the delivery of Covered Services by a Network Provider to a Member by means of audio, video or other electronic media for the purposes of diagnosis, consultation or treatment without in-person (face to face) contact between the provider and Member. Telemedicine does not include the use of audio-only telephone or facsimile.

Benefits are available for telemedicine service provided that all of the following conditions are met:

- The services must be furnished by a Network Provider, and

- The services would be covered if they were delivered during an in-person consultation instead of by telemedicine, and

- The services must be Medically Necessary as defined in Section 14 and

- Both the Network Provider and the Member must be present and participating during a telemedicine service.

Except as stated above, no Benefits are available for telemedicine services.

Cost sharing amounts for Covered telemedicine Services are the same as for similar services as shown on your Cost Sharing Schedule.

The Maximum Allowable Benefit for telemedicine services includes the provider's professional services and costs associated with operating the provider's practice. Unless additional Benefits would be available if services were delivered during an in-person consultation instead of by telemedicine, no additional Benefits are available for costs such as a provider's or Member's telephone and/or facsimile or e-mail transmissions, technology hardware or software costs, office, facility or home operating costs or other site location costs, fees for use of a facility or costs for equipment or for the services of vendors, including electronic/internet service provider costs.

G. **Online Visit Services**. In addition to the telemedicine services described above, Benefits are also available for online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See your Cost Sharing Schedule for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Noncovered Services include, but are not limited to, communications used for:

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

III. Outpatient Physical Rehabilitation Services

Benefits are available for Medically Necessary Outpatient Physical Rehabilitation Services. Coverage includes the following:

A. Physical Therapy, Occupational Therapy and Speech Therapy in an office or in the Outpatient department of a Short Term General Hospital or Skilled Nursing Facility. *Benefits are limited, as shown on your Cost Sharing Schedule.* Any combination of physical, occupational and speech therapy visits counts toward this limit.

Physical therapy must be furnished by a licensed physical therapist. Occupational therapy must be furnished by a licensed occupational therapist. Speech therapy must be furnished by a licensed speech therapist. Otherwise, no Benefits are available.

Speech therapy services must be Medically Necessary to treat speech and language deficits or swallowing dysfunctions during the acute care stage of a medical episode. Otherwise, no Benefits are available. Coverage for speech therapy is limited to the following speech therapy services:

1. An evaluation by a licensed speech therapist to determine if speech therapy is Medically Necessary, and

2. Individual speech therapy sessions (including services related to swallowing dysfunctions) by a licensed speech therapist.

Physical, occupational and speech therapy services must be furnished during the acute care stage of an illness or injury. Therapy is covered for long-term conditions only when an acute medical condition occurs during the illness, such as following surgery.

No Benefits are available for therapy furnished beyond the acute care stage of an illness or injury. Therapy services must be restorative, with the expectation of concise, measurable gains and goals as judged by your physician and by Anthem. Services must provide significant improvement within a reasonable and generally predictable period of time. Services must require the direct intervention, skilled knowledge and attendance of a licensed physical, occupational or speech therapist. Noncovered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes effecting the voice. Such on-going services are not covered, even if ordered by your physician or supervised by skilled program personnel. In addition to the limitations and exclusions listed in Section 8 of this Certificate, no Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities,

except as stated in D, "Early Intervention Services," below. No Benefits are available for sport, recreational or occupational reasons.

Physical therapy for TMJ disorders is not covered.

B. Cardiac Rehabilitation. Benefits are available for Outpatient cardiac rehabilitation programs. The program must meet Anthem's standards for cardiac rehabilitation. Otherwise, no Benefits are available. Please call Anthem at
1-800-531-4450 to determine program eligibility.

Covered Services are: exercise and education under the direct supervision of skilled program personnel in the intensive rehabilitation phase of the program. The program must start within three months after a cardiac condition is diagnosed or a cardiac procedure is completed. The program must be completed within six months of the cardiac diagnosis or procedure.

No Benefits are available for portions of a cardiac rehabilitation program extending beyond the intensive rehabilitation phase. Noncovered services include but are not limited to: on-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes. Such on-going services are not covered, even if ordered by your physician or supervised by skilled program personnel.

C. Chiropractic Care. Covered Services must be furnished by a Network Chiropractor. Otherwise, no Benefits are available. *Benefits are limited as shown on your Cost Sharing Schedule.*

The following are **Covered Services** when furnished by a Network Chiropractor:

1. **Office visits** for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment, and

2. Medically Necessary **diagnostic laboratory and x-ray tests**.

In addition to the limitations and exclusions stated in Section 8, the following limitations apply specifically to chiropractic care:

- Wellness care is not covered.

- The services must be Medically Necessary for the treatment of an illness or injury that is diagnosed or suspected by a Network Chiropractor or another physician, and

- Chiropractic care must be provided in accordance with New Hampshire law.

You may choose to receive noncovered services. However, you are responsible for the full cost of any chiropractic care that is not covered, as stated in this subsection.

D. Early Intervention Services. Early intervention services are covered for eligible Members from birth to the Member's third birthday. Eligible Members are those with significant functional physical or mental deficits due to a Developmental Disability or delay. Covered Services include Medically Necessary physical, speech/language and occupational therapy, nursing care, and psychological counseling provided by Network Behavioral Health Providers, such as Clinical Social Workers. Physical, speech and occupational therapy visits do not count toward any annual limits that may apply to A, (above).

IV. Home Care

Benefits are available for Medically Necessary Home Care. Covered Services are limited to the following:

A. Physician Services - physician visits to your home or place of residence to furnish medical/surgical care that is the same as or similar to services ordinarily provided in an office setting.

B. Home Health Agency Services. Benefits are available for Medically Necessary services furnished by a Network Home Health Agency in your home or other place of residence. In limited circumstances, Out-of-Network Services may be approved *in advance* by your PCP and by Anthem, provided that the Out-of-Network Provider is a BlueCard Provider.

Benefits are available only when, due to the severity of a medical condition, it is not reasonably possible for you to travel from your home to another treatment site.

Covered Services are limited to the following:

1. Part-time or intermittent skilled nursing care by, or under the supervision of a Registered Nurse,

2. Part-time or intermittent home health aide services that consist primarily of caring for you under the supervision of a Registered Nurse,

3. Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary. Otherwise, no Benefits are available. For example, if you are confined to bed rest or your activities of daily living are otherwise restricted by order of your Network Physician, prenatal and/or postpartum homemaker visits may be considered Medically Necessary. When determining the Medical Necessity of such services, your physician will consult with Anthem's case manager.

4. Physical, occupational, and speech therapy. Therapy provided by a Home Health Agency does not count toward annual limits that may apply to III, A (above).

5. Nonprescription medical supplies and drugs. Nonprescription medical supplies and drugs may include surgical dressings and saline solutions. Prescription drugs, certain intravenous solutions and insulin are not included. Please see your Pharmacy Rider for coverage information.

C. Hospice. Hospice care is home management of a terminal illness. Benefits are available for Covered Services, provided that the following conditions are met:

- Care must be approved *in advance* by the patient's Network Physician and Precertified by Anthem or the appropriate Local Plan,

- Care must be furnished by a Network Hospice Provider. In limited circumstances, Out-of-Network Services may be approved *in advance* by your PCP and by Anthem or the appropriate Local Plan, provided that the Out-of- Network Provider is a BlueCard Provider.

- The patient must have a terminal illness with a life expectancy of six months or less, as certified by a physician,

- The patient or his/her legal guardian must make an informed decision to focus treatment on comfort measures when treatment to cure the condition is no longer possible or desired,

- The patient or his/her legal guardian, the patient's physician and medical team must support hospice care because it is in the patient's best interest, and

- A primary care giver must be available on an around-the-clock basis. A primary care giver is a family member, friend or hired help who accepts 24-hour responsibility for the patient's care. The primary care giver does not need to live in the patient's home.

The hospice provider and Anthem will establish an individual hospice plan that meets your individual needs. Each portion of a hospice plan must be Medically Necessary and specifically approved *in advance* by Anthem's Precertification. Otherwise, no Benefits are available. Covered Services that may be part of the individual hospice plan are:

1. Skilled nursing visits,

2. Home health aide and homemaker services,

3. Physical therapy for comfort measures. These therapy services do not count toward annual visit limits that may apply to III, A, "Physical Therapy, Occupational Therapy and Speech Therapy" (above),

4. Social service visits,

5. Durable medical equipment and medical supplies.

6. Respite care (in the home) to temporarily relieve the primary care giver from care-giving functions,

7. Continuous care, which is additional respite care to support the family during the patient's final days of life,

8. Bereavement services provided to the family or primary care giver following the death of the hospice patient.

D. **Infusion Therapy.** Benefits are available for Medically Necessary home infusion therapy furnished by a licensed infusion therapy provider. Covered Services are:

1. Home nursing services for intravenous antibiotic therapy, chemotherapy or parenteral nutrition therapy,

2. Antibiotics, chemotherapy agents, medications and solutions used for parenteral nutrients,

3. Associated supplies and portable, stationary or implantable infusion pumps.

E. Durable Medical Equipment and Medical Supplies and Prosthetics. Benefits are available for durable medical equipment (DME), medical supplies and prosthetic devices. Covered Services must be ordered *in advance* by your Network Physician and furnished by a Network Provider. Out-of-Network Benefits are not available.

1. **Durable medical equipment (DME).** Benefits are available for covered DME. In order to be Covered, the DME must meet all of the following criteria. Otherwise, no Benefits are available. The DME must be:

   - Primarily and customarily used for a medical purpose, and

   - Useful only for the specific illness or injury that your physician has diagnosed or suspects, and

   - Non-disposable and specifically designed and intended to withstand repeated use, and

   - Appropriate for use in the home.

   Examples of covered DME include, but are not limited to: crutches, apnea monitors, oxygen and oxygen equipment, wheelchairs, special hospital type beds or home dialysis equipment. Enteral pumps and related equipment are covered for Members who are not capable of ingesting enteral formula orally. Oxygen humidifiers are covered if prescribed for use in conjunction with other covered oxygen equipment.

Benefits are available for external insulin infusion pumps for insulin dependent diabetics. External insulin pumps must be approved *in advance* by Anthem. **To determine eligibility, please ask your physician to contact Anthem for prior approval *before* you purchase the pump.** Anthem will require treatment and clinical information in writing from your physician. Anthem will review the information and determine in writing whether the services are covered or excluded under this Certificate, based on the criteria stated in this Certificate. You may contact Anthem to request a copy of Anthem's internal guidelines or go to Anthem's website, www.anthem.com. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment and Deductible, Coinsurance requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

Please see II, A "Preventive Care" (above in this Section) for information about external insulin pump education. Implantable insulin infusion pumps are not covered.

Benefits are also available for orthopedic braces for support of a weak portion of the body or to restrict movement in a diseased or injured part of the body.

Benefits are available for one hearing aid per ear each time a hearing aid prescription changes for Members who are **18** years old or younger. No Benefits are available for hearing aids for Members who are **19** years old or older.

2. **Medical Supplies.** Benefits are available for medical supplies. In order to be covered, medical supplies must be small, disposable items designed and intended specifically for medical purposes and appropriate for treatment of the specific illness or injury that your physician has diagnosed. Otherwise, no Benefits are available.

   Examples of covered medical supplies include: needles and syringes, ostomy bags and skin bond necessary for colostomy care.

   Eyewear (frames and/or lenses or contact lenses) is covered under this subsection only if the lens of your eye has been surgically removed or is congenitally absent. Please see subsection II, A "Preventive Care" for information about other coverage for eyewear prescribed for vision correction.

   Other covered medical supplies are:

   - **Diabetic supplies.** Diabetic supplies are covered for Members who have diabetes. Examples of covered diabetic supplies include, but are not limited to: diabetic needles and syringes, blood glucose monitors, test strips and lancets. Coverage is provided under this subsection when diabetic supplies are purchased from a licensed durable medical equipment Provider.

     Please note*: Diabetic supplies purchased at a pharmacy are not covered under this subsection. Please see your Pharmacy Rider for coverage information.*

   - **Enteral formula and modified low protein food products.** Benefits are available for **enteral formulas** required for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length or motility of the gastrointestinal tract. Benefits are available for **food products modified to be low protein** for persons with inherited diseases of amino acids and organic acids. Your physician must issue a written order stating that the enteral formula and/or food product is:

     - Needed to sustain life, and is
     - Medically Necessary; and is
     - The least restrictive and most cost-effective means for meeting your medical needs.

     Otherwise, no Benefits are available.

If you purchase these items as an Outpatient, Benefits are subject to the cost sharing amounts shown under part II of your Cost Sharing Schedule for "medical supplies".

3. **Prosthetic Devices.** Benefits are available for prosthetic devices that replace an absent body part or the function of a permanently impaired body part. Prosthetic limbs are covered. Prosthetic limbs are artificial devices that replace, in part or in whole, an arm or leg. Post-mastectomy breast prostheses and scalp hair prosthesis are other examples of covered prosthetic devices.

   Coverage for external breast prostheses is limited to 2 prostheses per breast, per Contract Year. The Maximum Allowable Benefit for breast prosthesis includes the cost of fitting for the prosthesis.

   Clothing necessary to wear a covered prosthetic is also covered. This includes stump socks worn with prosthetic limbs and post-mastectomy bras worn with external breast prosthesis. Coverage for post-mastectomy bras is limited to 3 bras per Member, per Contract Year.

   A **scalp hair** prosthesis is an artificial substitute for scalp hair that is made specifically for you. Benefits are available for scalp hair prostheses for Members who have hair loss as a result of alopecia areata, alopecia totalis, or alopecia medicamentosa resulting from treatment of any form of cancer or leukemia and/or who have permanent hair loss as a result of injury.

   To be eligible for Benefits for scalp hair prostheses, your physician must state in writing that the prosthesis is Medically Necessary. You must submit your physician's statement with your claim.

   Except as described above, no Benefits are available for scalp hair prostheses or wigs. For example, except as stated above, no Benefits are available for temporary hair loss. No Benefits are available for male pattern baldness.

4. **Limitations.** In addition to the limitations and exclusions listed in Section 8, the following limitations apply specifically to this subsection:

   - Whether an item is purchased or rented, Benefits are limited to the Maximum Allowable Benefit. Benefits will not exceed the Maximum Allowable Benefit for the least expensive service that meets your medical needs. If your service is more costly than is Medically Necessary, you will be responsible for paying the difference between the Maximum Allowable Benefit for the least expensive service and the charge for the more expensive service.

   - If you rent or purchase equipment and Anthem pays Benefits equal to the Maximum Allowable Benefit for the equipment, no further Benefits will be provided for rental or purchase of the equipment.

   - Anthem determines if equipment should be rented instead of purchased. For example, if your physician prescribes a hospital bed for short-term home use, Anthem will require that the bed must be rented instead of purchased if short-term rental is less expensive than the purchase price. In such instances, Benefits are limited to what Anthem would pay for rental, even if you purchase the equipment. You will be responsible for paying the difference between the Maximum Allowable Benefit for rental and the charge for purchase.

   - Burn garments (or burn anti-pressure garments) are covered only when prescribed by your physician for treatment of third degree burns, deep second degree burns or for areas of the skin that have received a skin graft. Covered burn garments include gloves, face hoods, chin straps, jackets, pants, leotards, hose or entire body suits which provide pressure to burned areas to help with healing.

   - Support stockings are covered for a diagnosis of phlebitis or other circulatory disease. Gradient pressure aids (stockings) are covered only when prescribed by your physician and provided that the stockings meet Anthem's definition of Medical Necessity, as stated in Section 14. Anti-embolism stockings are not covered. Inelastic compression devices are not covered. The

Maximum Allowable Benefit for covered gradient pressure aids includes the Benefit for fitting of the garments. No additional Benefits are available for fitting.

- Benefits are available for custom-fitted helmets or headbands (dynamic orthotic cranioplasty) to change the shape of an infant's head only when the service is provided for moderate to severe asymmetry (nonsynostotic plagiocephaly and brachycephaly) and the condition meets the definition of a **reconstructive service** found in subsection VI, G, "Surgery" below in this Section. To be eligible for Benefits, an infant Member must be at least three months old, but no older than 18 months. Also, the infant must have completed at least two months of cranial repositioning therapy or physical therapy with no substantial improvement. Otherwise, no Benefits are available for cranial helmets or any other device intended to change the shape of a child's head.

  Please contact Anthem for a copy of Anthem's internal guidelines. **The toll-free telephone number is 1-800-870-3122.**

- Benefits are available for broad or narrow band ultraviolet light (UVB) home therapy equipment only if the therapy is conducted under a physician's supervision with regularly scheduled exams. The therapy is covered only for treatment of the following skin disorders: severe atopic dermatitis and psoriasis, mild to moderate atopic dermatitis or psoriasis (when standard treatment has failed, as documented by medical records), lichen planus, mycosis fungoides, pityriasis lichenoides, pruritus of hepatic disease and pruritus of renal failure. UVB home therapy is not covered for any other skin disorder. Ultraviolet light A home therapy (UVA) is not covered. Please see Section 8, I, "Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders," for information about out-of-home ultraviolet light therapy.

5. **Exclusions.** In addition to the other limitations and exclusions stated in this Certificate, the following services are not covered. These exclusions apply, even if the services are provided, ordered or prescribed by a Designated Provider and even if the services meet Anthem's definition of Medical Necessity found in Section 14 of this Certificate.

   No Benefits are available for:

- Arch supports, corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification,

- Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds,

- Glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in this subsection,

- Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs, items for personal hygiene,

- Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans,

- Heat lamps, heating pads, hydrocoliator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems),

- Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device,

- Safety equipment, including, but not limited to: hats, belts, harnesses, glasses or restraints,

- Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system,

- Self-monitoring devices except as stated in 2 "Medical Supplies" (above), TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment; and

- Dentures, orthodontics, dental prosthesis and appliances. No Benefits are available for appliances used to treat temporomandibular joint (TMJ) disorders.

- Convenience Services are not covered under any portion of this Certificate. Please see Anthem's definition of "Convenience Services" in Section 8, II. For the purposes of this subsection, Convenience Services include, but are not limited to personal comfort items and any equipment, supply or device this is primarily for the convenience of a Member, the Member's family or a Designated Provider.

Except as specified in this subsection and in any amendment to this Certificate, no Benefits are available for the cost of medical equipment, supplies, prosthetics, materials or devices.

V. Behavioral Health Care (Mental Health and Substance Abuse Care)

A. Access to Behavioral Health Care. Benefits are available for Medically Necessary Behavioral Health Care. Behavioral Health Care means the Covered Services described in this subsection for diagnosis and treatment of Mental Disorders and Substance Abuse Conditions.

- **Network Services.** You must receive Covered Services from a Network Behavioral Health Provider. Exceptions are stated under "Out-lf-Network Services" below.

  Your PCP may refer you to a Network Behavioral Health Provider, but PCP Referrals are not required for Behavioral Health Care.

- **Out-of-Network Services.** In limited instances, Anthem may determine that it is Medically Necessary for you to receive Covered Services from an Out-of-Network Provider. **You (not your provider) must contact Anthem for Preauthorization *before* you receive any Out-of-Network Service, even if you are temporarily outside the Service Area for a definite period of time (such as students, vacationers and business travelers).**

  Please call Anthem at 1-800-228-5975 to request Preauthorization.

  After you call, Anthem will send you a letter specifying the Preauthorized Out-of-Network Services. If your Health Provider is named on the letter, you must receive Covered Services from the provider named. Otherwise, no Benefits will be available for the Out-of-Network Services.

  If Anthem notifies you that Out-of-Network Services are not approved, and you decide to receive the services, no Benefits will be available for the Out-of-Network Services and you will be responsible for the full cost of the care. No Benefits will be available for elective Inpatient or Outpatient care that can be safely delayed until you return to the Service Area or for care that a reasonable person would anticipate before leaving the Service Area. School infirmary facility or infirmary room charges are not covered under any portion of this Certificate. No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services.

If you fail to contact Anthem as required and Anthem later finds that your care did not meet the coverage criteria stated in this Certificate, no Benefits will be available and you will be responsible for the full cost of the care. The term "Preauthorization" for Out-of-Network Services refers to Anthem's written confirmation that it is Medically Necessary for you to receive care outside the Network. Preauthorization is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible and/or Coinsurance requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

- **Emergency Care.** Please see Section 6, "Emergency Care and Urgent Care." You must notify Anthem of an emergency Inpatient admission within 48 hours after you are admitted or on the next business day after you are admitted, whichever is later.

B. Covered Services. Benefits are available for the diagnosis, crisis intervention and short-term treatment of acute Mental Disorders and Substance Abuse Conditions.

- **A Mental Disorder** is a nervous or mental condition identified in the most current version of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, excluding those disorders designated by a "V Code" and those disorders designated as criteria sets and axes provided for further study in the DSM. This term does not include chemical dependency such as alcoholism. A mental disorder is one that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical or biological cause(s) or disorder(s).

- **A Substance Abuse Condition** is a condition, including alcoholism or other chemical dependency, brought about when an individual uses alcohol and/or other drugs in such a manner that his or her health is impaired and/or ability to control actions is lost. Nicotine addiction is not a Substance Abuse Condition under the terms of this Certificate.

In determining whether or not a particular condition is a Mental Disorder or Substance Abuse Condition, Anthem will refer to the most current edition of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association and may also refer to the International Classification of Diseases (ICD) Manual.

Benefits are available for the following Covered Services:

1. **Outpatient/office visits.** Covered Services are: diagnosis and evaluation, therapy and counseling, medication checks and psychological testing including but not limited to Medically Necessary psychological testing for bariatric surgery candidates. Visits for psychological testing and medication checks are covered. Emergency room visits are not covered under this subsection. Emergency room visits are covered under the terms of Section 6, "Emergency Care."

   Outpatient/office visits for Substance Abuse Conditions may be furnished during the acute detoxification stage of treatment or during stages of rehabilitation.

   Covered Outpatient/office visits for Mental Disorders and Substance Abuse Conditions must be furnished by an Eligible Mental Health or Substance Abuse Provider acting within the scope of his or her license. Otherwise, no Benefits are available. As defined in C (below) and subject to all the terms of this subsection, Eligible Providers of Outpatient/office visits are: Licensed Clinical Social Workers, Licensed Clinical Mental Health Counselors, Community Mental Health Centers, Licensed Alcohol and Drug Abuse Counselors, Licensed Marriage and Family Therapists, Licensed Pastoral Psychotherapists, Psychiatrists, Psychiatric Advanced Practice Registered Nurses, and Licensed Psychologists.

2. **Telemedicine Services.** Telemedicine is the delivery of Covered Services by an Eligible Behavioral Health Provider in the Network to a Member by means of audio, video or other electronic media for the purposes of diagnosis, consultation or treatment without in-person (face to face) contact between the provider and Member. Telemedicine does not include the use of audio-only telephone or facsimile.

Benefits are available for telemedicine service provided that all of the following conditions are met:

- The services would be covered if they were delivered during an in-person consultation instead of by telemedicine, and

- The services must be Medically Necessary as defined in Section 14, and

- Both the Network Provider and the Member must be present and participating during a telemedicine services.

Except as stated above, no Benefits are available for telemedicine services.

Cost sharing amounts for Covered telemedicine Services are the same as for similar services as shown on your Cost Sharing Schedule.

The Maximum Allowable Benefit for telemedicine services includes the provider's professional services and costs associated with operating the provider's practice. Unless additional Benefits would be available if services were delivered during an in-person consultation instead of by telemedicine, no additional Benefits are available for costs such as, but not limited to a provider's or Member's telephone and/or facsimile or e-mail transmissions, technology hardware or software costs, office, facility or home operating costs or other site location costs, fees for use of a facility or costs for equipment or for the services of vendors, including electronic/internet service provider costs.

3. **Online Visit Services**. In addition to the telemedicine services described above in subsection 7, II, G, Covered Services include a medical consultation using the internet via a webcam, chat or voice. See Cost Sharing Schedule for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Noncovered Services include, but are not limited to, communications used for:
   - Reporting normal lab or other test results
   - Office appointment requests
   - Billing, insurance coverage or payment questions
   - Requests for Referrals to doctors outside the online care panel
   - Benefit Precertification
   - Physician to physician consultation

4. **Partial Hospitalization and Intensive Outpatient Treatment Programs**. Benefits are available for Partial Hospitalization and Intensive Outpatient Treatment Programs (sometimes called "day/evening" programs) for treatment of Mental Disorders and for Substance Abuse rehabilitation. Covered Services include facility fees, counseling and therapy services typically provided by a Partial Hospitalization or Intensive Outpatient Treatment Program.

   Covered Services must be furnished by a Partial Hospitalization Program or Intensive Outpatient Treatment Program as defined in C, below and subject to all of the terms of this subsection. Otherwise, no Benefits are available.

5. **Inpatient care.**

   - **For Mental Disorders**, Covered Services include Medically Necessary semi-private room and board, nursing care and other facility fees, Inpatient counseling and therapy services typically provided as part of an Inpatient admission for treatment of Mental Disorders.

     Covered Services must be furnished by an Eligible Behavioral Health Provider, as defined in C (below) and subject to all of the terms of this subsection. Otherwise, no Benefits are available. Eligible Behavioral Health Providers of Inpatient facility care are: Private Psychiatric Hospitals, Public Mental Health Hospitals, Residential Psychiatric Treatment Facilities and Short Term General Hospitals.

- **For Substance Abuse Conditions,** Covered Services include Medically Necessary semi-private room and board, nursing care and other facility fees, Inpatient counseling and therapy services typically provided as part of an Inpatient admission for treatment of Substance Abuse Conditions during the acute detoxification stage of treatment or during stages of rehabilitation.

  Covered Services must be furnished by an Eligible Behavioral Health Provider, as defined in C (below) and subject to all of the terms of this subsection. Otherwise, no Benefits are available. Eligible Behavioral Health Providers of substance abuse detoxification are: Short Term General Hospitals and Private Psychiatric Hospitals. Eligible Providers of Inpatient facility rehabilitation are: Private Psychiatric Hospitals and Substance Abuse Treatment Providers.

  Please note: Inpatient admissions ordered by a medical/surgical physician (not an Eligible Behavioral Health Provider) for medical detoxification are not subject to the terms of this subsection. Precertification and notification rules are stated in Sections 4 and 6. Benefits are available as stated in subsection I, "Inpatient Services."

6. **Scheduled Ambulance Transport.** Benefits are available for Medically Necessary *scheduled* ambulance transport from one facility to another. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No Benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi. ***Please note:*** *Emergency* ambulance transportation is not covered under this subsection. Please see II, "Ambulance Services" for complete information.

C. Eligible Behavioral Health Providers. As approved by Anthem, Eligible Behavioral Health Providers include the following:

Licensed Clinical Social Worker - an individual who is licensed as a clinical social worker under New Hampshire law. Clinical Social Worker whose practice is conducted outside New Hampshire must be licensed or certified to practice independently as a Clinical Social Worker according to the law in the state where the individual's practice is conducted. Otherwise, the individual is not an Eligible Provider.

Licensed Clinical Mental Health Counselor - an individual who is licensed as a clinical mental health counselor under New Hampshire law. A Clinical Mental Health Counselor can also be an individual who is licensed or certified to practice independently as a Clinical Mental Health Counselor according to the provisions of law in another state where his or her practice is conducted.

Community Mental Health Center - a licensed center approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire as a Community Mental Health Center as defined in the Community Mental Health Centers Act of 1963 or licensed in accordance with the provisions of the laws of the state in which they practice which meet or exceed the certification standards of the State of New Hampshire.

Intensive Outpatient Treatment Program - an intensive, nonresidential behavioral health program designed to reduce or eliminate the need for an Inpatient admission. The program must provide multidisciplinary structured, therapeutic group treatment under the direction of a qualified Eligible Behavioral Health Provider. A qualified provider is an Eligible Behavioral Health Provider, as defined in this subsection, who has achieved at least a masters degree in his or her field of practice and is practicing within the scope of his or her license. In most instances, the program will operate at least three hours per day, three days per week.

Alcohol and Drug Abuse Counselor - an individual who is licensed as an Alcohol and Drug Abuse Counselor under New Hampshire law. An Alcohol and Drug Abuse Counselor may also be an individual whose practice is conducted outside New Hampshire must be licensed or certified to practice independently as an Alcohol and Drug Abuse Counselor according to the law in the state where the individual's practice is conducted. Otherwise, the individual is not a Designated Provider.

Licensed Marriage and Family Therapist - an individual who is licensed as a marriage and family therapist under New Hampshire law. A Marriage and Family Therapist can also be an individual who is licensed or certified to practice independently as a Marriage and Family Therapist according to the provisions of law in another state where

his or her practice is conducted. To be eligible for Benefits, Marriage and Family Therapists must furnish Covered Services as stated in Section 7, V. Marriage or couple's counseling is not covered under this Certificate.

Partial Hospitalization Program - means an intensive nonresidential behavioral health program designed to reduce or eliminate the need for an Inpatient admission. The program must provide multidisciplinary structured, therapeutic group treatment under the direction of a qualified Eligible Behavioral Health Provider. A qualified provider is an Eligible Behavioral Health Provider, as defined in this subsection, who has achieved at least a masters degree in his or her field of practice and is practicing within the scope of his or her license. In most instances, the program will operate at least 6 hours per day, five days per week.

Licensed Pastoral Psychotherapist - a professional who is licensed under New Hampshire law and who is a fellow or diplomate in the American Association of Pastoral Counselors.

Private or Public Hospital - a licensed Private Psychiatric Hospital or Public Mental Health Hospital that provides diagnostic services, treatment and care of acute Mental Disorders under the care of a staff of physicians. A Private or Public Hospital must provide 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.) and must keep permanent medical history records.

Psychiatrist - a professional who is a licensed physician and is Board Certified or Board Eligible according to the regulations of the American Board of Psychiatry and Neurology.

Psychiatric Advanced Practice Registered Nurse - a professional who is licensed as a registered nurse in advanced practice by the State of New Hampshire or licensed in accordance with the provisions of the laws of the state in which they practice and who is certified as a clinical specialist in psychiatric and mental health nursing.

Licensed Psychologist - a professional who is licensed under New Hampshire law, or under a similar statute in another state, which meets or exceeds the standards under New Hampshire law or is certified or licensed in another state and listed in the National Register of Health Service Providers in Psychology.

Residential Psychiatric Treatment Facility - a licensed facility approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire.

Short Term General Hospital - a health care institution having an organized professional and medical staff and Inpatient facilities which care primarily for patients with acute diseases and injuries with an average patient length of stay of 30 days or less.

Substance Abuse Treatment Provider - a facility that is approved by Anthem and which meets the following criteria: is licensed, certified or approved by the state where located to provide substance abuse rehabilitation, and is affiliated with a hospital under a contractual agreement with an established patient referral system, or is accredited by the Joint Commission on Accreditation of a Hospital as a Substance Abuse Treatment Provider.

Note: Benefits are provided for Covered Services furnished by Eligible Behavioral Health Providers located outside New Hampshire only when the services are Preauthorized by Anthem *in advance* or as otherwise required under this Certificate, and the provider is licensed according to state requirements that are substantially similar to those required by Anthem. Also, the provider must meet the educational and clinical standards that Anthem requires for health care provider eligibility. Otherwise, no Benefits are available.

D. Criteria for Coverage. To be eligible for Benefits, Covered Services must be Medically Necessary and must meet the following criteria:

Benefits are available only for Mental Disorders and Substance Abuse Conditions that are subject to favorable modification through therapy. The Mental Disorder or Substance Abuse Condition must be shown to affect the ability of a Member to perform daily activities at work, at home, or at school. Benefits are available for approved expenses arising from the diagnosis, evaluation and treatment of Mental Disorders and Substance Abuse Conditions. Additionally, Benefits are available for approved periodic care for a chronic Mental Disorder to prevent deterioration of function.

Services must be problem-focused and goal-oriented and demonstrate ongoing improvement in a Member's condition or level of functioning.

Services must be in keeping with national standards of mental health or substance abuse professional practice as reflected by scientific and peer specialty literature.

E. Exclusions. In addition to the limitations and exclusions stated in Section 8, no Benefits are available for the following:

- Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through therapy. Such disorders include, but are not limited to: mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders,

- Duplication of services (the same services provided by more than one therapist during the same period of time),

- Except for the psychological testing covered in B, 1, "Outpatient/office visits", no Benefits are available for therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

- Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling,

- Services for nicotine withdrawal or nicotine dependence,

- Psychoanalysis,

- Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings,

- Missed appointments,

- Except as stated in B "Covered Services," 2 "Telemedicine Services," and 3 "Online Visits Services" above, telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider,

- Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition,

- Care extending beyond therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting,

- Experimental/Investigational Services or nontraditional therapies such as crystal or aroma therapies,

- With the exception of Emergency Care, no Benefits are available for services that you receive on the same day that you participate in a partial hospitalization or intensive treatment program.

VI. IMPORTANT INFORMATION ABOUT OTHER COVERED SERVICES

This subsection includes services that are covered and often involve Covered Services defined elsewhere in this Section. For example, the Organ and Tissue Transplants described in D (below) involve Inpatient and Outpatient

services described throughout subsection I, “Inpatient Services” and II, “Outpatient Services” (above in this Section).

The limitations and exclusions stated in this subsection are in addition to those stated in Section 8. Limitations and exclusions apply even if you receive services from your physician or according to your physician’s order or according to the recommendation of another Designated Provider and even if the service meets Anthem’s definition of Medical Necessity. No Benefits are available for any services performed in conjunction with, arising from, or as a result of complications of a non-covered service. All of the plan rules, terms and conditions stated elsewhere in this Certificate apply to the services in this subsection.

A. Dental Services

Dental Services. Dental Services are defined as any care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and the soft or bony portions of upper and lower jaws that contain the teeth. For the purposes of this subsection, Dental Services also include care of the temporomandibular joint (TMJ) and Emergency Care in a hospital emergency room.

Under this Certificate, Benefits are limited to the following Covered Dental Services. No other Dental Service is a Covered Service. Except for Emergency Care in a hospital emergency room, Covered Services must be furnished by a Network Provider. Otherwise, no Benefits are available. The following Dental Services are Covered Services:

1. **Treatment of Accidental Injury to Sound Natural Teeth.** Benefits are available for Medically Necessary Dental Services resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is received or authorized within 3 months of the date of the injury.

   Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered consistent with terms and conditions of this certificate.

   No Benefits are available for diagnosis or treatment if you damage your teeth, supporting structures or appliances as a result of biting or chewing unless the biting or chewing results from a medical or mental condition. No Benefits are available to repair, restore or replace items such as fillings, crowns, caps or appliances.

   You do not need to obtain your Network Provider’s Referral for Emergency Care in the emergency room of a hospital to treat an accidental injury to sound natural teeth or gums. Please see Section 6, “Urgent and Emergency Care” for complete information. All other treatment must be furnished by a Network Provider. Otherwise, no Benefits are available.

   Cost sharing amounts for Covered Inpatient and Outpatient Dental Services are shown under parts I and II of your Cost Sharing Schedule.

2. **Oral Surgery** limited to the following:

   a. Surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease**. Services must be furnished by a Network Provider.** Otherwise, no Benefits are available. Benefits are limited to:

      - The surgeon’s fee for the surgical procedure,
      - Intravenous sedation furnished by the surgeon,
      - General anesthesia furnished by a licensed anesthesiologist or anesthetist who is not the surgeon.

      No Benefits are available for related preoperative or postoperative care, including medical, laboratory and x-ray services. No Benefits are available for related facility fees unless the provisions of 4 (below) apply.

b. Surgical correction of a facial bone fracture (not to include the portion of upper and lower jaws that contain the teeth, except as otherwise stated in this subsection) and surgical removal of a lesion or tumor by a dentist or oral surgeon are covered to the same extent as any other surgical procedure covered under this Certificate. **Services must be furnished by a Network Provider.** Otherwise, no Benefits are available. Cost sharing amounts for covered oral surgery, anesthesia, office and facility care are shown under parts I and II of your Cost Sharing Schedule.

3. **Diagnosis and surgical correction or repair of the temporomandibular joint (TMJ).** Benefits are available for medical exams and diagnostic x-rays of the temporomandibular joint (TMJ) and other facial bones to diagnose TMJ disorder. Surgical correction or repair of the TMJ is covered, provided that the Member has completed at least five months of medically documented unsuccessful non-surgical treatment. The non-surgical treatment is not covered.

   Coverage is limited to surgical evaluation and surgical procedures that are Medically Necessary to correct or repair a disorder of the TMJ caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations. Otherwise, no Benefits are available. Administration of general anesthesia by a licensed anesthesiologist or anesthetist is covered in conjunction with a covered surgery. Medically Necessary Inpatient and Outpatient hospital care is covered in conjunction with a covered surgery, subject to all of the terms of this Certificate. Cost sharing amounts for surgery, anesthesia and facility care are shown under parts I and II of your Cost Sharing Schedule.

   Services must be furnished by a Network Provider. Otherwise, no Benefits are available. Cost sharing amounts for surgery, anesthesia and facility care are shown under parts I and II of your Cost Sharing Schedule.

   Except as stated in this subsection, no Benefits are available for diagnosis, evaluation or treatment of the TMJ. diagnostic arthroscopy for TMJ disorders and trigger point injections are not covered. Except as stated in this subsection, no Benefits are available for non-surgical TMJ services, x-rays of the teeth, or orthopantagrams. Physical therapy for TMJ disorders is not covered. TMJ appliances or appliance adjustments are not covered. No Benefits are available under any portion of this Certificate for orthodontia, orthodontics, orthodontic care, dentures or dental prosthesis for TMJ disorders.

4. **Benefits are available for hospital facility charges (Inpatient or Outpatient), surgical day care facility charges and general anesthesia** furnished by a licensed anesthesiologist or anesthetist when it is Medically Necessary for certain Members to undergo a dental procedure under general anesthesia in a hospital facility or surgical day care facility. Members who are eligible for facility and general anesthesia Benefits are:

   a. **Children under the age of 6**. The child's dental condition must be so complex that the dental procedure must be done under general anesthesia and must be done in a hospital or surgical day care facility setting. A licensed dentist and the child's PCP must determine *in advance* that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's dental condition. Anthem must approve the care *in advance*.

   b. **Members who have exceptional medical circumstances or a Developmental Disability**. The exceptional medical circumstance or the Developmental Disability must be one that places the Member at serious risk unless the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting. The Member's Network Physician and Anthem must approve the services *in advance.*

   Cost sharing amounts for Inpatient and Outpatient facility charges and for general anesthesia are shown under parts I and II of your Cost Sharing Schedule. No Benefits are available for a noncovered dental procedure, even when your physician and Anthem authorize hospitalization and anesthesia for the procedure.

5. **Limitations and Exclusions**. In addition to the limitations and exclusions stated in Section 8, the following limitations and exclusions apply to Dental Services:

a. Except as specifically stated in 1 to 4 above, no Benefits are available for facility fees, professional fees, anesthesia related to Dental Services or any other care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and the soft or bony portions of upper and lower jaws that contain the teeth. Except as specifically stated in 3 above, no Benefits are available for any service relating to care of the temporomandibular joint (TMJ). Except as stated in 4 (above) for facility and general anesthesia services, no Benefits are available for treatment of cavities or care of the gums. No Benefits are available for any condition that is related to, arising from or is a complication of a noncovered service.

b. The Maximum Allowable Benefit for surgery includes the Benefit payment for IV sedation and/or local anesthesia. For any surgical Dental Service covered under this subsection, no Benefits beyond the surgical Maximum Allowable Benefit are available for IV sedation and/or local anesthesia.

c. Except as stated in 4 above, no Benefits are available for treatment or evaluation of a periodontal disorder, disease or abscess. Osseous and flap procedures, scaling, root planning, prophylaxis and periodontal evaluations are not covered even if they are furnished in conjunction with a covered gingivectomy.

d. No Benefits are available for preventive Dental Services.

e. Except as stated in 1 and 4 above in this subsection, no Benefits are available for restorative Dental Services, even if the underlying dental condition affects other health factors. No Benefits are available for noncovered dental procedures, even when your physician and Anthem authorize hospitalization and general anesthesia covered under this subsection.

f. X-rays of the teeth are covered only when the terms of 1 (above) are met. Otherwise, x-rays of the teeth are not covered under any portion of this Certificate. Orthopantagrams are not covered.

g. Orthodontia, TMJ appliances, splints or guards, braces, false teeth and biofeedback training are not covered under any portion of this Certificate. Orthopedic repositioning splints and occlusal adjustments are not covered under any portion of this Certificate. Night guards, trismus appliances, bruxism splints or occlusal guards are not covered under any portion of this Certificate.

h. No benefits are available for local anesthesia services. Except as specifically stated in this subsection, no Benefits are available for office services, anesthesia services or facility fees. Except

as stated in 4 above in this subsection, no Benefits are available for surgical exposure of impacted teeth to aid eruption, osseous and flap procedures, scaling, root planing, tooth build up, prophylaxis and periodontal evaluations.

i. No Benefits are available for biofeedback training.

j. No Benefits are available for diagnostic arthroscopy.

B. Hearing Services

Benefits are available for *diagnosis and treatment of ear disease or injury*. Your Network Physician must find or suspect injury to the ear or a diseased condition of the ear. Otherwise, no Benefits are available. For example, Benefits are available for laboratory hearing tests furnished by a Network Audiologist, provided that your Network Physician finds or suspects injury to the ear or a diseased condition of the ear. No Benefits are available for hearing aids except as stated in IV, “Durable Medical Equipment and Medical Supplies.”

Covered Services (Inpatient and Outpatient care) are described throughout Section 7. Cost sharing amounts are shown under parts I and II of your Cost Sharing Schedule.

Except as stated in subsection II, A "routine hearing exams," no Benefits are available for *routine* hearing services to determine the need for hearing correction.

C. Infertility Diagnostic Services

Benefits are available for diagnostic services to determine the cause of medically documented infertility. For the purposes of determining Benefit availability, "infertility" is defined as the diminished or absent capacity to create a pregnancy. Infertility may occur in either a female or a male.

Infertility may be suspected when a presumably healthy woman who is trying to conceive does not become pregnant after her uterus has had contact with sperm during 12 ovulation cycles in a period of up to 24 consecutive months, as medically documented. For women over age 35, infertility may be suspected after a woman's uterus has had contact with sperm during six ovulation cycles in a period of up to 12 consecutive months, as medically documented.

Anthem may waive the applicable time limits when the cause of infertility is known and medically documented. Please note that menopause in a woman is considered a natural condition and is not considered "infertility" for the purposes of determining Benefit availability under this health plan.

To be eligible for Benefits, Covered Services must be Medically Necessary and:

- Furnished by a Network Provider, or
- Approved *in advance* by your PCP's Referral and furnished by a Network Provider.

1. **Covered Services.** Benefits are available for the following Covered Services to determine the cause of medically documented infertility:

    - Medical exams,
    - Laboratory tests, including sperm counts and motility studies, sperm antibody tests, cervical mucus penetration tests,
    - Surgical procedures, and
    - Ultrasound and other imaging exams, such as hysterosalpingography to determine the cause of infertility or to establish tubal patency.

    Covered Services may be provided to male or female Members. Coverage is not available to partners who are not Members.

    Benefits for Covered Services are subject to cost sharing amounts as shown under parts I and II of your Cost Sharing Schedule for medical exams, laboratory and x-ray tests, surgery and anesthesia.

2. **Limitations and Exclusions**. Except as stated above, no Benefits are available under the terms of this Certificate for any service to diagnose or treat infertility or for any care (Inpatient or Outpatient) related to a noncovered service.
    No Benefits are available under any portion of this Certificate for the following services or for any care related to these services:

    - Medical exams, consultations and surgical procedures to treat or correct the cause of infertility or to treat or correct medical conditions contributing to infertility,

- Male or female fertility drugs and hormones, and any service to prescribe or monitor the use of fertility drugs or hormones,

- Medical care, sonograms (ultrasounds), laboratory services, radiological services or any other service related to treatment of infertility,

- Egg or sperm procurement or processing (including donor services), egg or sperm banking, storage or, microfertilization (egg drilling or tweaking) and electroejaculation procedures,

- Intracervical or intrauterine (IUI) artificial insemination (AI), using the partner's sperm (AIH) or donor sperm (AID),

- Assisted reproduction technology (ART) such as intravaginal culture, in-vitro fertilization and embryo transfer (IVF-ET) such as natural oocyte retrieval (NORIF or NORIVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT),

- Cryopreservation of donor eggs, cryopreservation of embryos or cryopreserved embryo transfer (CET), intracytoplasmic sperm injection (ICSI), preimplantation genetic diagnosis (PGD),

- Reversal of voluntary sterilization; diagnosis and treatment following voluntary sterilization or sterilization reversal (successful or unsuccessful),

- Any service related to achieving pregnancy through surrogacy or gestational carriers,

- Sex selection, genetic engineering, sperm penetration assays, microvolume straw technique, hamster penetration test (SPA),

- Any infertility procedure performed during an operation not related to an infertility diagnosis,

- Culture and fertilization of oocytes, co-culture of embryos and assisted embryo hatching,

- Direct intraperitoneal insemination (DIPI), peritoneal ovum and sperm transfer (POST),

- Costs related to donor eggs for or from women with genetic oocyte defects, or donor sperm for or from men with genetic sperm defects,

- Supplies (such as thermometers and kits to predict ovulation),

- Menopause in a woman is considered a natural condition and is not considered to be infertility, as defined above. No Benefits are available for infertility diagnosis, procedures or treatment for a woman who is menopausal or perimenopausal (or for their male partners), unless the woman is experiencing menopause at a premature age.

- Except as stated in this subsection, no Benefits are available for any services to diagnose the cause of infertility or to treat infertility. No Benefits are available for any service that is an Experimental/Investigational Service, as defined in Section 8, II. No Benefits are available for any service that is not Medically Necessary, as defined in Section 14.

If you have questions about Benefit eligibility for a proposed Infertility Service, you are encouraged to contact Anthem *before* you receive the service. Your physician should submit a written description of the proposed service to: Anthem Blue Cross and Blue Shield, P.O. Box 660 North Haven, CT 06473-0660. Anthem will review the information and determine in writing whether the requested service is covered or excluded under this Certificate. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible, Coinsurance requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding coverage for Infertility Services. Please see Section 11 for complete information.

D. Organ and Tissue Transplants

To be eligible for Benefits, transplants must be approved *in advance* according to your Network Physician's Referral and Anthem's Precertification. You and the organ donor must receive services from a Network Provider, Contracting Provider or other Designated Provider, as determined by Anthem. Otherwise, no Benefits are available.

The organ recipient must be a Member. When the organ donor is a Member, and the recipient is a not a Member, no Benefits are available for services received by the donor or by the recipient.

Exception: Human leukocyte antigen laboratory tests (histocompatibility locus antigen testing) to screen for the purposes of identifying a Member as a potential bone marrow transplant donor is covered, even if there is no specified recipient at the time of screening and/or an identified recipient is not a Member. Benefits are limited to the Maximum Allowable Benefit as allowed by law. New Hampshire law prohibits providers from billing Members for the difference between the Maximum Allowable Benefit and the provider's charge.

This screening for potential donors is covered only if, at the time of the testing:

1. The Member meets the criteria for testing as established by the Match Registry (the National Marrow Donor Program), and

2. The screening is furnished by a Network Provider acting within the scope of the provider's license.

   Otherwise, no Benefits are available for human leukocyte antigen testing to identify potential bone marrow transplant donors when the recipient is not a Member.

Benefits are available only if you meet all of the criteria for transplant eligibility as determined by Anthem and by the provider. The transplant must be generally considered the treatment of choice by Anthem and by the provider. Otherwise, no Benefits are available. Transplants are not covered for patients with certain systemic diseases, contraindications to immunosuppressive drugs, positive test results for HIV (with or without AIDS), active infection, active drug, alcohol or tobacco use or behavioral or psychiatric disorders likely to compromise adherence to strict medical regimens and post-transplant follow-up.

Covered Services. The following transplants are covered if all of the conditions stated in this subsection are met.

- Cornea, heart, heart-lung, kidney, kidney-pancreas, liver, and pancreas,

- Allogeneic (HLA identical match) bone marrow transplants for acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma (for children who are at least one year old), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Thalassemia major and Wiskott-Aldrich syndrome,

- Autologous bone marrow (autologous stem cell support) transplants and autologous peripheral stem cell support transplants for acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.

- Single or double lung transplants for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension and emphysema. Double lung transplants are covered for cystic fibrosis.

- Small bowel transplants for Members with short bowel syndrome when there is irreversible intestinal failure, an established TPN (total parenteral nutrition) dependence for a minimum of two Years, or there is evidence of severe complications from TPN. Simultaneous small bowel/liver transplants are covered for children and adults with short bowel syndrome when there is irreversible intestinal failure, an established

TPN dependence for a minimum of two Years, evidence of severe complications from TPN or evidence of impending end-stage liver failure.

Due to advances in transplant procedures and constantly changing medical technology, Anthem reserves the right to periodically review and update the list of transplant procedures that are Covered Services. For the most up-to-date list of covered transplant procedures, please contact Customer Service. **The toll-free telephone number is 1-800-870-3122.**

Benefits are available for the tissue typing, surgical procedure, storage expense and transportation costs directly related to the donation of a human organ or other human tissue used in a covered transplant procedure. Benefits are available only to the extent that the costs are not covered by other insurance.

Covered Services (Inpatient and Outpatient) are stated throughout Section 7. Covered Services are subject to the cost sharing amounts shown in parts I and II of your Cost Sharing Schedule.

No Benefits are available for any transplant procedure that is not a Covered Service as described in this subsection. Experimental/Investigational transplant procedures and any related care (including care for complications of a non-covered procedure) are not covered except as stated in E, below for "Qualified Clinical Trials." No Benefits are available for procedures that are not Medically Necessary. No Benefits are available for any service or supply related to surgical procedures for artificial or nonhuman organs or tissues. No Benefits are available for transplants using artificial parts or nonhuman donors. Benefits are not provided for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes but is not limited to: services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a human heart transplant.

E. Qualified Clinical Trials: Routine Patient Care

Benefits are available for Medically Necessary routine patient care related to drugs and devices that are the subject of clinical trials, provided that all of the following terms and conditions are met:

1. The drug or device under study must be approved for sale by the FDA (regardless of indication).

2. The drug or device under study must be for cancer or any other life-threatening condition.

3. The drug or device must be the subject of a clinical trial approved by one of the following:

   - A National Institutes of Health (NIH),
   - An NIH cooperative group or an NIH center,
   - The FDA (in the form of an Investigational new drug application or exemption)
   - The federal department of Veterans Affairs or Defense, or
   - An institutional review board of an institution in New Hampshire that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH.

4. Standard treatment has been or would be ineffective, does not exist or there is no superior non-Investigational treatment alternative.

5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.

6. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-Investigational alternative.

7. For phase III or IV clinical trials (clinical trials involving leading therapeutic or diagnostic alternatives) Benefits are available for routine patient care, provided that all of the conditions stated in this subsection are met, and subject to all of the other terms and conditions of this Certificate.

8. For phase I or II clinical trials (clinical trials involving emerging technologies), Benefits are available for routine patient care only if:

   - All of the conditions stated in this subsection are met and subject to all of the other terms and conditions of this Certificate, and

   - Anthem reviews all of the information available regarding your individual participation in a Phase I or II clinical trial and determines that Benefits will be provided for your routine patient care. Otherwise, no Benefits are available for routine patient care related to phase I or II clinical trials.

Routine patient care means the Medically Necessary Covered Services described in this Certificate for which Benefits are regularly available, no applicable exclusion is stated in this Certificate and for which reimbursement is regularly made to a Network Provider according to the terms of the provider's agreement with Anthem. For example, if surgery is Medically Necessary to implant a device that is being tested in a phase III or IV clinical trial, the surgery and any Medically Necessary hospital care are covered according to the terms and conditions of this Certificate. Plan rules and cost sharing rules apply to routine patient care as for any other similar service. Cost sharing amounts for routine patient care costs are shown in the applicable parts of your Cost Sharing Schedule. For example: your share of the cost for Inpatient services is found in section I of the Cost Sharing Schedule and your share of the cost for Infusion Therapy is found in section IV. For Phase I and II clinical trials, Anthem determines Benefit eligibility for routine patient care on a case-by-case basis.

Routine patient care does not include:

- The drug or device that the trial is testing,

- Experimental/Investigational drugs or devices not approved for market for any indication by the FDA,

- Non-health care services that a Member may be required to receive in connection with the clinical trial or services that are provided to you for no charge,

- Services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis,

- The cost of managing the research associated with the clinical trial. This includes, but is not limited to items or services provided primarily to collect data, and not used in the direct provision of Medically Necessary health care services. For example, monthly CT scans for a condition that usually requires fewer scans are not routine patient care,

- Services that are not Medically Necessary, as defined in Section 14 of this Certificate, any service not specifically stated as a Covered Service in this Certificate. Services subject to an exclusion or limitation stated in this Certificate are not routine patient care.

F. Required Exams or Services

No Benefits are available for examinations or services that are ordered by a third party and are not Medically Necessary to treat an illness or injury that your physician finds or reasonably suspects. No Benefits are available for examinations or services required to obtain or maintain employment, insurance or professional or other licenses. No

Benefits are available for examinations for participation in athletic or recreational activities or for attending a school, camp, or other program, unless furnished during a covered medical exam, as described in Section 7.

Court ordered examinations or services are covered, provided that:

- The services are Medically Necessary Covered Services furnished by an Eligible Behavioral Health Provider or another Designated Provider, and
- All of the terms and conditions of this Certificate are met, including network restrictions, Referral and Precertification rules.

Covered Services are subject to the cost sharing amounts as shown under parts I, II and V of your Cost Sharing Schedule.

G. Surgery

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

A Surgical Assistant is a Designated Provider acting within the scope of his or her license who actively assists the operating surgeon in performing a covered surgical service. Benefits are available for the Medically Necessary services of a Surgical Assistant, provided that:

- The surgery is a Covered Service, **and**

The surgery is not on Anthem's list of surgical procedures that do not require a Surgical Assistant. Anthem's list is changeable. Please contact your physician or Customer Service before your surgery to obtain the most current information. **The toll-free telephone number is 1-800-870-3122.**

Administration of general anesthesia is covered, provided that:

- The surgery is a Covered Service, and
- The anesthesia is administered by a licensed anesthesiologist or anesthetist who is not the surgeon.

Surgery includes correction of fractures and dislocations, delivery of a baby, endoscopies and any incision or puncture of the skin or tissue that requires the use of surgical instruments to provide a Covered Service. Covered Services are subject to the cost sharing amounts shown under parts I and II of your Cost Sharing Schedule.

Under the terms of this subsection, surgery does not include: inoculation, vaccination, collection of blood or administration or injection of drugs. Surgery does not include any service excluded from coverage under the terms of this Certificate.

Limitations. In addition to the limitations and exclusions stated elsewhere in this Certificate, the following limitations apply to surgery:

1. **Reconstructive surgery**. Benefits are available for Medically Necessary reconstructive surgery only if at least one of the following criteria is met. **Reconstructive surgery or services must be:**
    - Made necessary by accidental injury; or
    - Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
    - Medically Necessary to restore or improve a bodily function, or
    - Necessary to correct birth defects for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate.
    - Benefits are available for breast reconstruction following mastectomy for patients who elect reconstruction. Breast reconstruction can include reconstruction to both effected breasts or one

effected breast. Reconstruction can also include reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast (to produce a symmetrical appearance) in the manner chosen by the patient and the physician.

Reconstructive surgery or procedures or services that do not meet at least one of the above criteria is not covered under any portion of this Certificate.

Provided that the above definition of reconstructive surgery is met, the following reconstructive surgeries are eligible for Benefits:

1. Mastectomy for Gynecomastia

2. Mandibular/Maxillary orthognathic surgery

3. Port wine stain removal

Benefits are available based on the criteria stated in this Certificate. For a copy of Anthem's internal guidelines, please contact Customer Service for assistance. **The toll-free telephone number is 1-800-870-3122.**

Please see subsection IV, E, "Durable Medical Equipment and Medical Supplies" for information about coverage for helmets or adjustable bands used to change the shape of an infant's head.

2. **Cosmetic Services**. Cosmetic Services are not covered under any portion of this Certificate. Please see Section 8, II for a definition of Cosmetic Services.

3. **Dental Services.** Dental Services are covered only as stated in A, "Dental Services" (above). Except as stated in A (above), no Benefits are available for Dental Services, including dental surgery, under any portion of this Certificate.

4. **Surgery for conditions caused by obesity**. Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity. Anthem's definition of Medical Necessity is found in Section 14. When applying the definition of Medical Necessity to bariatric surgery services, Anthem uses standards that are consistent with qualification and treatment criteria set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons.

   Surgery to treat the condition of obesity itself or morbid obesity itself is not covered under any portion of this Certificate, even if the surgery, service or program is ordered by your physician or performed or ordered by another Designated Provider. This exclusion applies even if the surgery, service or program meets Anthem's definition of Medical Necessity. Except as stated in this subsection, no Benefits are available for bariatric surgery or any other surgery intended to manage or control appetite or body weight.

   Please see "diabetes management" in subsection II, A, and "nutrition counseling" in subsection II A for information about Benefits for non-surgical services for weight management, management of obesity and treatment of the diseases and ailments caused by or resulting from obesity.

   No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision. This exclusion includes, but is not limited to, commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

5. **Postoperative medical care.** The Maximum Allowable Benefit for surgery includes the Benefit payment for postoperative medical care. No Benefits beyond the surgical Maximum Allowable Benefit are available for surgery-related postoperative medical care. Please see Section 14 for a definition of the Maximum Allowable Benefit.

6. **Organ/tissue transplant surgery.** Please see D, "Organ and Tissue Transplants" (above in this subsection) for important information about coverage and limitations for organ/tissue transplant surgery.

7. **Intravenous (IV) Sedation and local anesthesia.** The Maximum Allowable Benefit surgery includes the Benefit payment for IV sedation and/or local anesthesia. No Benefits beyond the surgical Maximum Allowable Benefit are available for IV sedation and/or local anesthesia.

8. **Surgery related to noncovered services**. No Benefits are available for surgery or any other care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. This exclusion applies even if the service is furnished or ordered by your Network Physician or other Designated Provider and meets Anthem's definition of Medical Necessity.

If your proposed surgical services may be considered noncovered reconstructive, cosmetic, dental, weight loss/weight management surgery or if your surgical services may be considered noncovered under other portions of this Certificate, you should contact Anthem *before* you receive the services. Please ask your physician to submit a written description of the service to: Anthem Blue Cross and Blue Shield, P.O. Box 660 North Haven, CT 06473-0660. Anthem will review the information and determine in writing whether the requested services are covered or excluded under this Certificate. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible, Coinsurance, the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

H. Vision Services

Benefits are available for *diagnosis and treatment of eye disease or injury*. Covered Services (Inpatient and Outpatient care) are described throughout this Section. Cost sharing amounts are shown under parts I and II of your Cost Sharing Schedule.

To be eligible for Benefits, Network Services must be furnished by a Network Provider. Out-of-Network Services are available only if you obtain your PCP's Referral and Anthem's Precertification *in advance*. Please see Section 4 for complete information about Out-of-Network Services.

Note: If the lens of your eye has been surgically removed or is congenitally absent, please see subsection IV, E "Durable Medical Equipment and Medical Supplies" for information about coverage for eyewear.

Please see subsection II, A "Preventive Care" for information about coverage for *routine* vision exams to determine the need for vision correction and eyewear prescribed for vision correction.

No Benefits are available for vision therapy including treatment such as vision training, orthoptics, eye training, or eye exercises.

SECTION 8: LIMITATIONS AND EXCLUSIONS

Please see Section 14 for definitions of specially capitalized words.

I. Limitations

The following are important limitations that apply to the Covered Services stated in Section 7. In addition to other limitations, conditions or exclusions set forth elsewhere in this Certificate, Benefits for expenses related to the services, supplies, conditions or situations described in this sub-section are limited as indicated below. Limitations apply to these items and services even if you receive them from your or Network Provider or according to a Referral from your PCP or Network Provider.

Please remember, this managed health care plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate. The following list of limitations is not a complete list of all services, supplies, conditions or situations for which Benefits are limited. Limitations are stated throughout this Certificate. If a service is not covered, then all services performed in conjunction with, arising from, or as a result of complications to that service is not covered.

Anthem makes determinations about Referrals, Precertification, Medical Necessity, Experimental/Investigational Services and new technology based on the terms of this Certificate, including, but not limited to the definition of Medical Necessity found in Section 14. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. Please see Section 11 for complete information about the appeal process.

A. Human Growth Hormones. No Benefits are available for human growth hormones, except:

- To treat children with short stature who have an absolute deficiency in natural growth hormone, or
- To treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

Benefits are subject to the cost sharing amounts as shown under section II "medical supplies" or section IV, "Infusion Therapy," depending on the provider of the services. Please see your Pharmacy Rider for information about coverage for human growth hormones purchased at a pharmacy for '"take-home" use.

B. Private Room. If you occupy a private room, you will have to pay the difference between the hospital's charges for private room and the hospital's most common charge for a semi-private room, unless it is Medically Necessary for you to occupy a private room. Your Network Physician must provide Anthem or the Local Plan with a written statement regarding the Medical Necessity of your use of a private room, and Anthem or the Local Plan must agree *in advance* that private room accommodations are Medically Necessary. Covered private room charges are subject to the cost sharing amounts as shown under part I of your Cost Sharing Schedule.

C. Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders. Benefits are available for out-of-home ultraviolet light and laser therapy as follows:

- Ultraviolet light therapy is covered for treatment of atopic dermatitis, chronic urticaria, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), pityriasis lichenoides, pityriasis rosea, pruritus of renal failure, psoriasis or vitiligo.
- Psoralen with Ultraviolet A light therapy is covered for treatment of acute or chronic pityriasis lichenoides, atopic dermatitis, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), psoriasis and vitiligo.

- Ultraviolet laser therapy for the treatment of inflammatory skin disorders such as psoriasis, provided that:
  - The inflammation is limited to less than or equal to 10% of the member's body surface area, and
  - The member has undergone conservative therapy with topical agents, with or without standard non-laser ultraviolet light therapy and the conservative therapy was not successful as documented in medical records. Except as stated in this subsection, no Benefits are available for ultraviolet light or laser therapy for skin disorders.

Please see Section 7, IV "Durable Medical Equipment and Medical Supplies" for information about coverage for home ultraviolet light therapy for skin disorders. Except as stated in Section 7 and in this subsection, no Benefits are available for ultraviolet light therapy or ultraviolet laser therapy for skin disorders.

II. Exclusions

No Benefits are available for the following items or services. This subsection is not a complete list of all noncovered services. Other limitations, conditions and exclusions set forth elsewhere in this Certificate. Please remember, this health plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate.

Anthem makes determinations about Referrals, Precertification, Medical Necessity, Experimental/Investigational services and new technology based on the terms of this Certificate, including, but not limited to the definition of Medical Necessity found in Section 14. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. Please see Section 11 for complete information about the appeal process.

No Benefits are available for the cost of any noncovered services or for the cost of any care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. The limitations and exclusions found in this subsection of this Certificate and in any other portion of this Certificate apply even if the service is furnished or ordered by your PCP or other Designated Provider and/or the service meets Anthem's definition of Medical Necessity.

Alternative Medicines or Complementary Medicine. No Benefits are available for alternative or complementary medicine, even if the service is recommended by your physician and even if the services are beneficial to you. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven, established or medically documented or otherwise fails to meet Anthem's definition of Medical Necessity as stated in Section 14. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

Amounts That Exceed the Maximum Allowable Benefit - Benefits for Covered Services are limited to the Maximum Allowable Benefit. As stated in this Certificate and your riders and endorsements, you may be responsible for any amount that exceeds the Maximum Allowable Benefit. See Section 14 for a definition of "Maximum Allowable Benefit."

Artificial Insemination - In general terms, "artificial insemination" refers to insemination by any means other than natural sexual intercourse. Except as stated in Section 7, VI, "Infertility Services," no Benefits are available under any portion of this Certificate for artificial insemination.

Biofeedback Services - Biofeedback services are not covered.

Blood and Blood Products - No Benefits are available for costs related to the donation, drawing or storage of designated blood. Designated blood is blood that is donated and then designated for a specific person's use at a later date. No Benefits are available for blood, blood donors, blood products or packed red blood cells when participation in a volunteer blood program is available.

Care Furnished by a Family Member - No Benefits are available for care furnished by an individual who normally resides in your household or is a member of your immediate family. Anthem defines your immediate family to include parents, siblings, spouses, children and grandparents.

Care Received When You Are Not Covered Under This Certificate. No Benefits are available for any service that you receive before the effective date of this Certificate.

If an Inpatient admission begins before the effective date of this Certificate and this coverage replaces that of a prior carrier, Benefits will be provided under this Certificate for Inpatient days occurring on or after the effective date of this Certificate, unless the terms of the prior carrier's Certificate or policy provide coverage for the entire admission (admission date to discharge date), and subject to all of the terms and conditions of this Certificate for Medically Necessary Inpatient services.

Except as stated in Section 13, III, Benefits are not available for Inpatient days or any other services that occur after the termination date of coverage under this Certificate.

Care or Complications Related To Noncovered Services. No Benefits are available for the cost of any noncovered services or for the cost of any care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services, except as stated in Section 7, VI, A, "Dental Services." The limitations and exclusions found in this Section and in any other portion of this Certificate apply, even if the service is furnished or ordered by your physician or other Designated Provider and/or the service meets Anthem's definition of Medical Necessity. Benefits for any complications resulting from noncovered or unauthorized services are excluded from coverage.

Chelating Agents - No Benefits are available for any service, supply or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.

Convenience Services - No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Noncovered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges.

Cosmetic Services - No benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical condition caused by or providing in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services. Cosmetic Services include but are not limited to any care, procedure, service, equipment, supplies or medications primarily intended to change your appearance, to improve your appearance or furnished for psychiatric or psychological reasons. For example: surgery or treatments to change the texture or appearance of your skin are not covered. No Benefits are available for surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except for the covered surgery described in Section 7, VI, "Surgery."

Custodial Care. No Benefits are available for services, supplies or charges for Custodial Care. Custodial Care is not covered, even if the services are furnished or prescribed by a Designated Provider. Custodial Care is primarily for the purpose of assisting you in the activities of daily living. and is not specific treatment for an illness or injury. It is care that has minimal therapeutic value and cannot in itself be expected to substantially improve a medical condition. Custodial Care is excluded, even if you receive the care during the course of an illness or injury while under the supervision of a Designated Provider, and even if the care is prescribed or furnished by a Designated

Provider and is beneficial to you. Custodial Care is not covered, whether or not it is furnished in a facility (such as a Short-term General Hospital, Skilled Nursing Facility or Physical Rehabilitation Facility), at home or in another residential setting. Noncovered Custodial Care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Oral hygiene, ordinary skin and nail care, maintaining personal hygiene or safety;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Routine maintenance of ostomies;
- Catheter care
- Suctioning;
- Using the toilet;
- Enemas;
- Preparation of special diets;
- Supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel, and
- Domiciliary care. Domiciliary care is care provided in a residential institution or setting, 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. Domiciliary care is Custodial Care and is not covered under any portion of this Certificate.
- Convalescent care. Convalescent care is Custodial Care that you receive during a period of recovery from an acute illness or injury.

Disease or Injury Sustained as a Result of War or Participation in Riot or Insurrection. No Benefits are available for care required to diagnose or treat any illness or injury that is a result of war or participation in a riot or an insurrection.

Domiciliary Care. Domiciliary care is care provided in a residential institution or setting, 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. Domiciliary care is Custodial Care and is not covered under any portion of this Certificate.

Educational, Instructional, Vocational Services and Developmental Disability Services. Except as stated in Section 7, II, "diabetes management programs," and III "Cardiac Rehabilitation Programs," no Benefits are available for educational or instruction programs or services. Noncovered services include, but are not limited to education evaluation, testing, classes, therapy, tutoring, counseling, programs, equipment or supplies. No Benefits are available for vocational/occupational evaluations, testing, classes, therapy, counseling, programs, equipment or supplies.

No Benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities except as stated in Section 7, "Covered Services" subsection III, C "Early Intervention Services."

Experimental/Investigational Services. Except as stated in Section 7, VI, "Qualified Clinical Trials," Anthem will not pay for Experimental/Investigational Services. No Benefits are available for the cost of care related to, resulting from, arising from or provided in connection with Experimental/Investigational Services. No Benefits are available for care furnished for complications arising from Experimental/Investigational Services.

A. "Experimental or Investigational Service" means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply that is Experimental or Investigational and is used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition.

A drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational if one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought:

- The service 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
- The service has been determined by the FDA to be contraindicated for the specific use; or
- The service 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
- The service is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- The service 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. A service that is not Experimental or Investigational based on the criteria in A (above) may still be Experimental or Investigational if:

- The scientific evidence is not conclusory concerning the effect of the service on health outcomes;
- The evidence does not demonstrate that 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;
- The evidence does not demonstrate that the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence does not demonstrate that the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

D. When applying the provisions of A and B (above) to the administration of Benefits under this health plan, Anthem may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) 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
- The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting providers and other experts in the field.

Anthem uses the terms of this subsection in reviewing services that may be Experimental/Investigational. Anthem's medical policy assists in Anthem's review. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Experimental/Investigational Services. Please see Section 11 for complete information.

Food and Food Supplements. Except as required by applicable law, no Benefits are available for foods, food supplements or for vitamins. Please see Section 7, IV, "Durable Medical Equipment and Medical Supplies" for information about Benefits for some of these items. Please see your Pharmacy Rider for information about coverage for some of these items.

Foot Care, (Routine) Foot Orthotics and Corrective Shoes. No Benefits are available for routine foot care. Services or supplies in connection with corns, calluses, flat feet, fallen arches, weak feet or chronic foot strain are not covered. No Benefits are available for foot orthotics, inserts or support devices for the feet. Corrective shoes are not covered.

Free Care. Benefits are not provided for any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this Certificate or under any other health plan or other insurance.

Government Programs. Benefits are not available for Covered Services to the extent that benefits for such services are paid or payable (or could reasonably be expected to be payable if a claim were made) under any of the following:

- Medicare or any other federal, state or local government program for which the government is the primary payer, including CHAMPUS/TRICARE. Exception: Benefits are available under this Certificate even though you may be eligible for Medicaid,
- Any federal, state, county, municipal, or other government agency, including Medicare and the Veteran's Administration, for service-connected disabilities

Please see Section 10 for more information regarding Medicare.

Health Club Memberships. No Benefits are available for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Hearing Aids. Except as stated in Section 7, IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics," no Benefits are available for hearing aids. This exclusion includes, but is not limited to: charges for batteries, cords, and individual or group auditory training devices.

Home Test Kits - No Benefits are available for laboratory test kits for home use. These include, but are not limited to, home pregnancy tests and home HIV tests.

Hospitalization for Noncovered Services. No Benefits are available for hospital services or any other health care service related to, arising from, the result of, caused by or provided in connection with noncovered services or for complications arising from noncovered services, except as stated in Section 7, VI, A, "Dental Services." No Benefits are available for expenses incurred when you choose to remain in a hospital or another health care facility beyond the discharge time recommended by your physician, or by Anthem.

Missed Appointments - Physicians and other providers may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No Benefits are provided for these charges. You are solely responsible for the charges.

Non-Hospital Institutions - No Benefits are available for care or supplies in any facility that is not specifically stated as a covered facility in this Certificate. No Benefits are available for care or supplies in convalescent homes or similar institutions and facilities that provide primarily custodial, maintenance or rest care. No Benefits are available for care or supplies in health resorts, spas, sanitariums, sanatoriums or tuberculosis hospitals.

Nonmember Biological Parents - No Benefits are available for services received by the biological parent of an adopted child, unless the biological parent is a Member.

Nutrition and/or Dietary Supplements. Except as provided in this Certificate or as required by law, no Benefits are available for nutrition and/or dietary supplements. This exclusion includes those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. Please see Section 7 "Covered Services," IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics," for information about Benefits for some of these items. Please see your Pharmacy Rider for coverage information.

Pharmacy Services. No Benefits are available under this Certificate for prescription drugs purchased at a retail or mail service pharmacy, doctor's office or facility for "take home" use. Except as specifically stated in this Certificate, no Benefits are available for any drug, medication, supply, equipment, device, service or care furnished by a pharmacy. Please see your Pharmacy Rider for information about coverage for services purchased at a pharmacy for "take-home" use.

Premarital Laboratory Work - Premarital laboratory work required by any state or local law is not covered.

Private Duty Nurses - Benefits are not provided for private duty nurses.

Processing Fees - No Benefits are available for the cost of obtaining medical records or other documents that Anthem considers necessary to administer Benefits under this Certificate.

Rehabilitation Services. No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.

Reversal of Voluntary Sterilization. No Benefits are provided for the reversal of sterilization, including infertility treatment that is needed as a result of a prior elective or voluntary sterilization (or elective sterilization reversal) procedure.

Routine Care or Elective Care Outside the Service Area - Benefits are not available for routine care outside the Service Area. Routine care includes, but is not limited to, routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, immunizations or other preventive care. Elective care is care that can be delayed until you can contact your PCP, Network Obstetrician/Gynecologist or Anthem for direction. Examples of elective care include, but are not limited to: scheduled Inpatient admissions or scheduled Outpatient care.

Sclerotherapy for Varicose Veins and Treatment of Spider Veins. Except when treatment is Medically Necessary as defined in Section 14 of this Certificate, no Benefits are available for sclerotherapy for the treatment of

varicose veins of the lower extremities including, but not limited to: ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by sclerotherapy or any other method is not covered under any portion of this Certificate because such treatment is considered to be cosmetic and not Medically Necessary.

Services Not Covered and Care Related to Noncovered Services. No Benefits are available for services that are not specifically described as Covered Services in this Certificate. No Benefits are available for services that are not covered due to a limitation or exclusion stated in this Certificate. This exclusion applies even if the service meets Anthem's definition of Medical Necessity and it applies even if a Designated Provider furnishes or orders the service. No Benefits are available for care related to, resulting from, arising from, caused by or provided in connection with noncovered services or for complications arising from noncovered services. Examples of noncovered services include but are not limited to:

- Services furnished by any individual or entity that is not a Designated Provider, except at the sole discretion of Anthem,
- Services received by someone other than the patient, except as stated in Section 7, VI "Organ and Tissue Transplants,"
- A separate fee for the services of interns, nurses, residents, fellows, physicians or other providers such as hospital-based ambulance services that are salaried or otherwise compensated by a hospital or other facility,
- The travel time and related expenses of a provider,
- A provider's charge to file a claim or to transcribe or duplicate your medical records,
- Fees, postage, taxes or other charges for the shipping or handling of covered equipment or services,
- Prescription drugs purchased at a retail pharmacy, doctor's office or through a mail service pharmacy for "take-home" use. Please see your Pharmacy Rider for information about prescription drugs purchased at a pharmacy for take-home use.
- Nonlegend or "over-the-counter" drugs, medications, vitamins, minerals, supplements, supplies or devices. Please see your Pharmacy Rider for information about prescription drugs purchased at a pharmacy for take-home use.

Sex Change Treatment. No Benefits are available for surgical procedures or any other service, drug, product or therapy related to altering your sex from one gender to the other.

Smoking Cessation Drugs, Programs or Services. Except as required by law under Section 7, "Covered Services" II, A "Preventive Care," no Benefits are available for smoking cessation programs, products, drugs or medications, hypnosis, supplies or devices of any kind intended to help you quit smoking or to wean you off nicotine. Such services are not covered, even if administered in a physician's office, ordered by a physician or if a physician's written prescription order is required for purchase of the service.

Surrogate Parenting. Costs associated with surrogate parenting or gestational carriers are not covered. For other related exclusions, please see "Infertility Services" in Section 7, VI.

Transportation. No Benefits are available for transportation costs, except as described in 7, II, "Ambulance Services".

Unauthorized Care - No Benefits are available for any service that you receive without obtaining a required Referral from your PCP or Network Physician in advance. No Benefits are available for any care related to, resulting from, arising from or provided in connection with the noncovered services or for complications arising from the care. This exclusion applies even if the service is furnished by a Designated Provider and meets Anthem's

definition of Medical Necessity. Except as specified in this Certificate or at Anthem's discretion, Benefits are available only when Covered services are:

- Furnished by a physician (most often your Network Physician), or
- Ordered by a physician (most often your Network Physician) and furnished by a Designated Provider.

Workers' Compensation - This Certificate does not provide Benefits for any condition, disease, or injury that arises out of or in the course of employment when you are covered by Workers' Compensation, unless you have waived coverage in accordance with state law.

X-rays. No Benefits are available for diagnostic x-rays in connection with research or study, except as explained for routine patient care costs in Section 7, VI, "Qualified Clinical Trials." No Benefits are available for orthopantagrams.

SECTION 9: CLAIM PROCEDURE

Please see Section 14 for definitions of specially capitalized words.

This Section explains Anthem's procedure regarding the submission and processing of claims. For the purposes of this Section, **Claim Denial** means any of the following: Anthem's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a member's eligibility for coverage under this Certificate. Claim Denial also includes Anthem's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of Anthem's utilization review procedures, as well as Anthem's failure to cover a service for which benefits are otherwise provided based on Anthem's determination that the service is Experimental, Investigational or not Medically Necessary or appropriate.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. A claim may 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.

I. Post-Service Claims

Post-Service Claims are claims for services that you have received. Post-Service Claims do not include requests for reimbursement made by providers according to the terms of an agreement with Anthem or with a Subcontractor, unless:

- Benefits are reduced or denied, *and*
- Under the terms of an agreement with Anthem or with a Subcontractor, the provider can bill you for amounts exceeding your Copayment, Deductible and/or Coinsurance.

A. Time Limit for Submitting Post-Service Claims. In order for Anthem make payments for Post-Service Claims, Anthem must receive your claim for Benefits within 12 months after you receive the service. Otherwise, Benefits will be available only if:

- It was not reasonably possible to submit the claim within the 12-month period, and
- The claim is submitted as soon as reasonably possible after the 12-month period.

If services are furnished by an Out-of-Network Provider, you may need to submit your own claim form. Please contact your Group Benefits Administrator or Anthem to obtain the correct claim form as prescribed by Anthem for submission. Anthem's **toll-free telephone number is 1-800-870-3122.** Please complete the claim form, include your itemized bill and any information about other insurance payment and submit the claim to the address indicated on the claim form.

B. Timeframe for Post-Service Claim Determinations. Anthem will make a Post-Service Claim determination within 30 days after receipt of the claim unless you or your authorized representative fail to provide the information needed to make a determination. In the case of such failure, Anthem will notify you within 15 days after receipt of the claim. Anthem's notice will state the specific information needed to make a determination. You will be provided at least 45 days to respond to Anthem's notice. The period of time between the date of the request for information and the date of Anthem's receipt of the information is "carved out" of (does not count against) the 30-day time frame stated in this paragraph.

II. Pre-Service Claims

Certain services are covered in part or in whole only if you request and obtain Precertification *in advance* from Anthem. Requests for Precertification and Preauthorization, submitted under the terms of this Certificate, are Pre-Service Claims. Pre-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreements with Anthem or a Subcontractor.

Pre-Service Claims may be non-urgent or urgent.

An example of a **non-urgent Pre-Service Claim** is a request for Precertification of a scheduled Inpatient admission for elective surgery.

An **Urgent Care Claim** means a request for Precertification or Preauthorization submitted as *required* under this Certificate, for care or treatment with respect to which the application of time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the proposed care or treatment.

A. Time Limit for Submitting Pre-Service Claims. Unless it is not reasonably possible for you to do so, Pre-Service Claims must be submitted within the applicable time frames stated in this Certificate or in any riders or endorsements that amend this Certificate. For example, as stated in Sections 1 and 6, you must request Precertification within 48 hours after an Emergency Inpatient admission.

B. Timeframes for Making Pre-Service Claim Determinations. Anthem will make a determination about your Pre-Service Claim within the following time frames. Time frames begin when your claim is received and end when a determination is made.

- **For non-Urgent Claims** a determination will be made within a reasonable time period, but in no more than 15 days after receipt of the claim. Exception: the initial 15 day period may be extended one time for up to 15 additional days, provided that Anthem finds that an extension is necessary due to matters beyond the control of Anthem. Before the end of the initial 15 day period, you will be notified of the circumstances requiring an extension. The notice will also inform you of the date by which a decision will be made. If the extension is necessary because you or your authorized representative failed to provide the information needed to make a determination, the notice of extension will specify the additional information needed. You will be given at least 45 days from receipt of the notice to provide the specified information. The determination will be made as soon as possible, but in no case later than 15 days after the earlier of 1) receipt of the specified information by Anthem, or 2) the end of the period afforded to you to provide the specified information.

- **For Urgent Care Claims** a determination will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. Exception: If you or your authorized representative fail to provide the information needed to make a determination, Anthem will notify you within 24 hours after receipt of the claim. The notice will include the specific information necessary to make a determination. You will be given no less than 48 hours to provide the information. The determination will be made as soon as possible, but in no case later than 48 hours after the earlier of 1) receipt of the specified information by Anthem, or 2) the end of the period afforded to you to provide the specified information.

For Urgent Care Claims Relating to *both* the Extension of an Ongoing Course of Treatment *and* a Question of Medical Necessity, a determination will be made within 24 hours of receipt of the claim, provided that you make the claim at least 24 hours *before* the approved period of time or course of treatment expires.

No fees for submitting a Pre-Service Claim will be assessed against you or your authorized representative. You may authorize a representative to submit or pursue a Pre-Service Claim or Benefit determination by submitting your written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact Customer Service. **The toll-free telephone number is 1-800-870-3122.**

Exception: For Urgent Care Claims, Anthem will consider a health care professional with knowledge of your condition (such as your treating physician) to be your authorized representative without requiring your written acknowledgment of the representation.

III. Notice of a Claim Denial

Anthem's notice of a Post-Service or a Pre-Service Claim Denial will be in writing or by electronic means and will include the following:

A. The specific reason(s) for the determination, including the specific provision of your plan on which the determination is based,

B. A statement of your right to access the internal appeal process and the process for obtaining external review. In the case of an Urgent Care Claim Denial or when the denial is related to continuation of an ongoing course of treatment for a person who has received emergency services, but who has not been discharged from a facility, Anthem will include a description of the expedited review process, If the Claim Denial is based upon a determination that the claim is Experimental/Investigational or not Medically Necessary or appropriate, the notice will include:

1. The name and credentials of Anthem's Medical Director, including board status and the state(s) where the Medical Director is currently licensed. If a person or other licensed entity making the Claim Denial is not the Medical Director but a designee, the designee's credentials, board status, and state(s) of current license will be included, and

2. An explanation of the clinical rationale or the scientific judgment for the determination. The explanation will recite the terms of your plan or of any clinical review criteria or internal rule, guideline, protocol or other similar provision that was relied upon in making the denial and how these provisions apply to your specific medical circumstances.

C. If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in making the Claim Denial, a statement that such guideline was relied upon. A copy of the guideline will be included with the notice, or you will be informed that a copy is available free of charge upon request,

D. If clinical review criteria were relied upon in making any Claim Denial, the notice will include a statement that such criteria were relied upon. The explanation of any clinical rationale provided under the terms of C, 2. (above) will be accompanied by the following notice: "The clinical review criteria provided to you are used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the Benefits covered under your Certificate."

Anthem will not release proprietary information protected by third party contracts.

IV. Appeals

Please see Section 11 for complete information about the Appeal Procedure. The Appeal Procedure is part of Anthem's Claim Procedure.

V. General Claims Processing Information

A. Network Provider Services. When you receive Covered Services from a Network Provider, you will not have to fill out any claim forms. Simply identify yourself as a Member and show your Anthem identification card

before you receive the care. Network Providers will file claims for you. You pay only the applicable Copayment, Deductible or Coinsurance amount to the Provider when you receive your Covered Services. Eligible Benefits will be paid directly to Network Providers.

B. Out-of-Network Services. When you receive a Covered Service from an Out-of-Network Provider in New Hampshire or a nonBlueCard Provider, you may have to fill out a claim form. You can get claim forms from Anthem's Customer Service Center. The toll-free telephone number is 1-800-870-3122. Mail your completed claim form to Anthem, along with the original itemized bill.

When you are traveling outside the country, you should obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States currency. To determine the United States currency amount, please use the exchange rate, as it was on the date you received the care.

Out-of-Network New Hampshire Providers and nonBlueCard Providers may ask you to pay the entire charge at the time of your visit. It is up to you to pay the provider. Generally, Anthem will pay eligible Benefits directly to you. Benefits equal the Maximum Allowable Benefit, minus any applicable Copayment, Deductible or Coinsurance amount. You may be responsible for amounts that exceed the Maximum Allowable Benefit and for the applicable Copayment, Deductible or Coinsurance amounts.

Anthem reserves the right to pay either you or the hospital or any other provider. You cannot assign any Benefits or monies due under this Certificate to any person, provider, corporation, organization or other entity. Any assignment by you will be void and have no effect. Assignment means the transfer to another person, provider, corporation, organization or other entity of your right to the Benefits available under this Certificate.

C. Inter-Plan Programs. Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

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

Anthem covers only limited healthcare services received outside of Anthem's corporate parent's service area. As used in this section "Out-of-Area Covered Healthcare Services" include emergency care, urgent care, or Authorized Services obtained outside the geographic area Anthem's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your Primary Care Physician ("PCP").

BlueCard® Program. Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem's contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard® Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount, as stated in your Cost Sharing Schedule.

Emergency Care Services. If you experience a Medical Emergency while traveling outside the Anthem service area, go to the nearest Emergency or Urgent Care facility.

Whenever you access covered healthcare services outside Anthem's and, if applicable, Anthem's corporate parent's service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

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

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

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

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

SECTION 10: OTHER PARTY LIABILITY

Please see Section 14 for definitions of specially capitalized words.

The following guidelines apply to all claims that are submitted for payment under the provisions of Coordination of Benefits (COB), the Medicare Program, Subrogation, Reimbursement and Workers' Compensation.

I. Coordination of Benefits (COB)

Please Call Customer Service and ask for the coordination of benefits operator if you have questions about any portion of this Section. The toll-free telephone number is 1-800-870-3122.

Please note: You may not hold, or obtain Benefits under both this plan and a nongroup (individual) health insurance policy issued by Anthem or any other insurer.

The following guidelines apply to all claims that are submitted for payment under the provisions of Coordination of Benefits (COB), the Medicare Program, Subrogation, Reimbursement and Workers' Compensation.

A. Coordination of Benefits (COB). COB sets the payment responsibilities when you are covered by more than one health or dental care plan or policy. COB is intended to prevent duplication of payment and overpayments for Covered Services furnished to Members. If any Member is covered under another health care plan or policy, Benefits for Covered Services will be coordinated as stated in this Section.

For purposes of this Section only, "health care plan" or "policy" means any of the following, which provide Benefits or services for, or by reason of, medical or dental care or treatment:

- Group or individual hospital, surgical, dental, medical or major medical coverage provided by Anthem Blue Cross and Blue Shield (Anthem), a private insurer or an insurance company, an HMO, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured), a prepayment group or individual practice plan, or a prepayment plan of any other organization. COB applies to any coverage including self-insured, self-funded or unfunded benefit plans or plans administered by a government, such as "socialized medicine" plans. COB also applies to union welfare plans, employee or employer benefit organizations, or any other insurance that provides medical benefits,

- Except as stated in this Section, any insurance policy, contract or other arrangement or insurance coverage, where a health or dental benefit is provided, arranged or paid, on an insured or uninsured basis,

- Any coverage for students sponsored by, provided through or insured by a school, sports program or other educational institution above the high school level except for school accident type coverage.

- The medical benefits coverage in automobile "no fault" or "personal injury protection" (PIP) type contracts, not including medical payments coverage, also known as Part B in the personal automobile policy or med pay.

For the purposes of this Section, the terms "health care plan" or "policy" do not refer to: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; medical payments coverage in a personal automobile policy, also known as Part B or med pay coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

The term "health care plan or policy" will be interpreted separately with respect to:

- Each policy, contract or other arrangement for benefits or services; or

- That portion of any such policy, contract or other arrangement for benefits or services which reserves the right to take the benefits of the other health care plan or policy into consideration in determining its benefits and that portion which does not take such benefits into consideration.

COB also applies when you are covered by more than two policies.

Please remember that your cost sharing amounts (such as Copayments, Deductible, Coinsurance, or annual and lifetime maximums) are your responsibility whether Anthem is the Primary or the Secondary plan. Also, plan rules apply as stated in this Section whether Anthem is the Primary or the Secondary plan. For example, any applicable provider network or participation rules apply.

B. Definitions. The following definitions apply to the terms of this Section:

Primary means the health or dental care plan or policy that is responsible for processing your claims for eligible benefits first. When this health care plan is the Primary plan, Anthem will provide the full extent of Benefits for services covered under this Certificate, up to Anthem's Maximum Allowable Benefit without regard to the possibility that another health care plan or policy may cover some expenses.

Secondary means the plan responsible for processing claims for Allowable Expenses after the Primary plan has issued a benefit determination. When this health care plan is Secondary, Benefits under this plan may be reduced so that payments from all health care plans or policies combined do not exceed 100% of the total Allowable Expense.

Allowable Expense means a health or dental care service expense that is eligible for Secondary Benefits under this health care plan. Allowable Expenses include, but are not limited to, to any deductible, coinsurance and copayment cost shares required under a Primary plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered to be the benefit available under that plan.

The following limitations apply to Allowable Expenses:

- An expense must be for a Medically Necessary Covered Service, as defined in this Certificate. Otherwise, no portion of the expense is an Allowable Expense.

- When the Primary plan has provided full benefits and there is no Member liability for claim payment, no portion of the expense is an Allowable Expense.

- When the Primary plan has provided benefits and there is Member liability for claim payment, the following rules apply to Secondary coverage under this plan:

  a. If all plans covering the claim compute benefits or services based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for the specific claim is not an Allowable Expense.

  b. If all plans covering the claim compute benefits or services based on a negotiated fee, any amount in excess of the highest negotiated fee for the specific claim is not an Allowable Expense.

  c. If one plan computes benefits or services for a claim based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology and another computes benefits or services based on a negotiated fee, the Primary plan's payment arrangement shall be the Allowable Expense for all plans. Exception: If a Network Provider contracts with Anthem to accept a negotiated amount as payment in full when Anthem is the

  d. Secondary payer and such negotiated amount differs from the Primary payer's arrangement, Anthem's negotiated amount will be the Allowable Expense used to determine Secondary Benefits. The total amount in payments and/or services provided by all payers combined will not exceed Anthem's Maximum Allowable Benefits.

- If the Primary plan bases payment for a claim on the provider's full charge and does not utilize usual and customary fees, relative value schedule reimbursement methodologies, other similar reimbursement methodologies and does not negotiated fees with providers, the combination of benefits paid by the Primary plan and this plan will not exceed Anthem's Maximum Allowable Benefit. The difference between Anthem's Maximum Allowable Benefit and the provider's charge is not an Allowable Expense.

- When benefits are reduced under a Primary plan due to an individual's failure to comply with the Primary plan's provisions, the amount of the reduction is not an Allowable Expense. Examples of these types of plan provisions include, but are not limited to: managed care requirements for second surgical opinions, Inpatient and Outpatient Precertification requirements and rules about access to care (such as network restrictions and referral rules).

- Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

- The amount that is subject to the Primary high-deductible health plan's deductible is not an Allowable Expense if Anthem has been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

C. The Order of Payment is Determined by COB. COB uses the following rules to determine the Primary and Secondary payers when you are covered by more than one health or dental care plan or policy.

Important General Rules:

- **Medicare Program**. Medicare Secondary Payer (MSP) laws determine whether Medicare benefits will be Primary or Secondary to the Benefits available under this Certificate or any rider, endorsement or other amendment to this Certificate. Factors that determine which plan is Primary include, but are not limited to: the number of individuals employed by your Group, your status as an active employee, your age and the reason that you are eligible for Medicare. If Medicare is the Secondary plan according to MSP laws, coverage under this Certificate is Primary. If Medicare is the Primary plan according to MSP laws, the Group coverage for which you are eligible is Secondary.

  If you are entitled to Medicare benefits when you enroll in this plan, you must inform your Group Benefits Administrator and state this information on your enrollment form. If you become entitled to Medicare benefits after you enroll, you must inform your Group Benefits Administrator and Anthem immediately. You should also contact your local Social Security Office right away to discuss Medicare rules regarding enrollment in Parts A, B and D of Medicare.

- To the extent permitted by applicable law, when any Benefits are available as Primary Benefits to a Member under Medicare or any Workers' Compensation Laws, Occupational Disease Laws and other employer liability laws, those Benefits will be Primary.

- If you have coverage under this plan and any plan outside the U.S.A. (including plans administered by a government, such as "socialized medicine" plans), the out-of-country plan is Primary when you receive care outside the U.S.A. This plan is Primary when you receive services in the U.S.A. This rule applies before any of the following rules (including the rules for children of separated or divorced parents).

- Except for group coverage that supplements a basic part of a benefit package and provides supplementary coverage (such as major medical coverage superimposed over base hospital/surgical coverage) any health care plan or policy that does not contain a coordination of benefits provision consistent with the terms of this Section is always Primary.

D. Order of Payment Rules. If you are covered by more than one health or dental care plan or policy and none of the rules listed in "General Rules" (above) apply, the order of benefits will be determined by using the first of the following rules that apply:

- **Non-Dependent/Dependent.** If you are the employee or Subscriber under one policy and you are a dependent under the other, the policy under which you are an employee or Subscriber is Primary. Exception: If you are a Medicare beneficiary and, as a result of federal law, Medicare is Secondary under the plan covering you as a dependent and Primary to the Plan covering you as an employee or Subscriber, then the order of benefits is reversed so that the plan covering you as an employee or Subscriber is the Secondary plan and the other plan is Primary.

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

  1. For a dependent child whose parents are married or are living together, whether or not they have ever been married, the following "birthday rule" applies:
     a. The plan of the parent whose birthday falls earlier in the Calendar Year is Primary, or
     b. If both parents have the same birthday, the plan that has covered the parent the longest is Primary.
  2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
     a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is Primary. This rule applies to plan years commencing after the plan is given notice of the court decree, or
     b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of 1. above (the birthday rule) shall determine the order of benefits.
     c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of 1. above (the birthday rule) shall determine the order of benefits.
     d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        (1). The plan covering the Custodial parent;
        (2). The plan covering the spouse of the Custodial parent;
        (3). The plan covering the non-Custodial parent; and then
        (4). The plan covering the spouse of the non-Custodial parent.

        A Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.
     e. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of 1 or 2 above shall determine the order of benefits as if those individuals were the parents of the child.

- **Active Employee or Retired or Laid-off Employee**. The plan that covers a Member as an active employee (that is - an employee who is neither laid off nor retired) is Primary. The plan covering that same Member as a retired or laid-off employee is Secondary. The same rule applies if a Member is a dependent of an active employee and that same Member is a dependent of a retired or laid-off employee. If the other

plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent/Dependent" rule (above) can determine the order of benefits.

- **COBRA or State Continuation Coverage.** If a Member is covered under COBRA or a similar "right of continuation" law under either federal or a state law, and the Member is also covered under another policy that is not a continuation policy, the continuation coverage is Secondary and the other plan is Primary. If the other plan does not have this rule and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent/Dependent" rule (above) can determine the order of benefits.

- **Longer/Shorter Length of Coverage**. The Plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is Primary and the plan that covered the Member the short period of time is Secondary.
- **If the preceding rules do not determine the order of benefits**, Allowable Expenses shall be shared equally between the health care plans or policies. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

II. Workers' Compensation

No Benefits are available for any care, condition, disease or injury that arises out of or in the course of employment when you are covered by Workers' Compensation, unless you or your employer waived coverage in accordance with New Hampshire law.

III. Subrogation and Reimbursement

These provisions apply when Anthem pays benefits as a result of injuries, illness, impairment or medical condition you sustain and you have a right to a recovery or have received a recovery. For the purposes of this Section, "recovery" shall mean money you receive from another, the other's insurer or from any "Home Owner's," "Uninsured Motorist," "Underinsured Motorist," "No-Fault," "Personal Injury Protection" or other insurance coverage provision as a result of injury, illness, impairment or medical condition caused by another party. These provisions do not apply to medical payments coverage, also known as Part B in a personal automobile policy or med pay. Regardless of how you or your representative or any agreements characterize the recovery you receive, it shall be subject to the Subrogation and Reimbursement provisions of this section.

Benefits will be provided for medical care paid, payable or required to be provided under this Certificate, and the Benefits paid, payable or required to be provided. Anthem must be reimbursed by the Member for such payments as permitted under applicable law from medical payments coverage and other property and casualty insurance including but not limited to automobile and homeowners insurance coverage.

Anthem may reduce any Benefit paid, payable or required to be paid under this Certificate by the amount that the Member has received in payment from medical payments coverage and other property and casualty insurance including but not limited to automobile and homeowners insurance coverage.

If benefits are exhausted under a medical payments coverage or other similar property and casualty insurance, Benefits are available under this plan, subject to all of the terms and conditions of this Certificate.

Subrogation. If you suffer an injury, illness, impairment or medical condition that is the result of another party's actions, and Anthem pays Benefits to treat such injury, illness, impairment or medical condition, Anthem will be subrogated to your Recovery rights. Anthem may proceed in your name against the responsible party. Additionally, Anthem shall have the right to recover payments made on your behalf from any party responsible for compensating

you for your injury, illness, impairment or medical condition. All of the following shall apply, except to the extent limited by applicable law:

- Anthem may pursue its subrogation rights for the full amount of Benefits Anthem has paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.

- You and your legal representative must do whatever is necessary to enable Anthem to exercise the rights set forth in this Section and do nothing to prejudice such rights.

- Anthem has the right to take whatever legal action is seen fit against any party or entity to recover Benefits paid under this Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Anthem's subrogation claim and any claim still held by you, Anthem'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.

- Anthem is not responsible for any attorney fees, other expenses or costs you incur without the prior written consent of Anthem.

Nothing in this Section shall be construed to limit Anthem's right to utilize any remedy provided by law to enforce its rights to subrogation under this Section. If you are injured or suffer an impairment or medical condition that is the result of another party's actions, and Anthem pays Benefits to treat such injury or condition, Anthem will be subrogated to your recovery rights. Anthem is entitled to reimbursement from the responsible party or any other party you receive payment from to the extent of Benefits provided. Anthem's subrogation right includes, but is not limited to underinsured or uninsured motorists' coverage. By accepting this Certificate, you agree to cooperate with Anthem and do whatever is necessary to secure Anthem's right and do nothing to prejudice these rights. Anthem reserves the right to compromise on the amount of the claim if Anthem determines that it is appropriate to do so. Any action that interferes with Anthem's subrogation rights may result in the termination of coverage for the Subscriber and covered dependents.

Reimbursement. If you obtain a Recovery, Anthem has a right to be repaid from the Recovery up to the amount of the Benefits paid by Anthem on your behalf.

IV. Anthem's Rights Under this Section

Anthem reserves the right to:

- Take any action needed to carry out the terms of this Section, and

- Exchange information with your other insurance company or other party, and

- Recover Anthem's excess payment from another party or reimburse another party for its excess payment, and

- Take these actions when Anthem decides they are necessary without notifying the Member.

This provision is not intended to permit dissemination of information to persons who do not have a legitimate interest in such information. Neither does this provision permit (in any manner) the dissemination of information prohibited by law.

Whenever another plan or entity pays benefits that should have been made by Anthem in accordance with this Section, Anthem has the right, at its sole discretion, to pay the other plan or entity any amount that Anthem determines to be warranted to satisfy the intent of this Section. Amounts so paid are Benefits under this Certificate and, to the extent of such payments, Anthem is fully discharged from liability under this Certificate.

If Anthem has provided Benefits subject to reimbursement or subrogation and you recover payments from another source which you do not pay to Anthem, Anthem has the right to offset these amounts against any other amount that would otherwise be payable under this Certificate.

Anthem's recovery rights. On occasion, a payment may be made to you or on your behalf when you are not covered, for a service that is not covered, or which is more than is appropriate for that service. When incorrect payment or overpayment is made, Anthem has the right to recover such payment from any Member, person or entity (including any Member, provider, insurance company or health care plan) to whom or for whom such payment was made. Anthem will notify any Member who is subject to a recovery action. The Member must either remit the required amount to Anthem or provide Anthem with written notice of the reasons the Member may be entitled to such payment. The written notice or recovery amount must be submitted to Anthem within 60 days of Anthem's recovery notice. If you receive a recovery notice from Anthem and repayment is a financial hardship to you, please ask about an interest free installment plan. Anthem's mailing address and toll-free telephone number appear on the recovery notice.

Under certain circumstances, if Anthem pays the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Anthem may collect such amounts directly from you. You agree that Anthem has the right to collect such amounts from you.

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

V. Your Agreement and Responsibility Under This Section

You have the responsibility to provide prompt, accurate and complete information to Anthem about other health coverages and/or insurance policies or benefits you may have in addition to Anthem coverage. Other health coverages, insurance policies or benefits include, but are not limited to, benefits from other health coverage, Worker's Compensation, and/or claims against liability or casualty insurance companies arising from any injury, illness, impairment or medical condition you receive. By accepting this Certificate, you agree to cooperate with Anthem, and you agree to provide information about any other health coverage on an annual basis or when necessary to carry out the terms of this Section.

By accepting this Certificate, you must:

- Promptly notify Anthem of how, when and where an accident or incident resulting in personal injury, illness, impairment or medical condition to you occurred and all information regarding the parties involved,
- Cooperate with Anthem in the investigation, settlement and protection of rights,
- Not do anything to prejudice the rights Anthem,
- Send to Anthem copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury, illness, impairment or medical condition to you, and/or
- Promptly notify Anthem if you retain an attorney or if a lawsuit is filed on your behalf. Any action which interferes with Anthem's under this Section or the Certificate may result in the termination of coverage for the Subscriber and covered Dependents.

SECTION 11: MEMBER SATISFACTION SERVICES AND APPEAL PROCEDURE

Please see Section 14 for definitions of specially capitalized words.

This Section explains how to contact Anthem when you have questions, suggestions, concerns or complaints.

I. Member Satisfaction Services

Anthem provides quality member satisfaction services through Customer Service Centers. All personnel are responsible for addressing your concerns in a manner that is accurate, courteous, respectful and prompt. Customer Service Representatives are available to:

- Answer questions you have about your membership, your Benefits, Covered Services, the network, payment of claims, and about policies and procedures,
- Provide information or health plan materials that you want or need (such as health promotion brochures, the network directory, or replacement of identification cards),
- Make sure your suggestions are brought to the attention of the appropriate persons, and
- Provide assistance to you (or your authorized representative) when you want to file an internal appeal.

Your identification number helps to locate your important records with the least amount of inconvenience to you. Your identification number is on your identification card. Please be sure to include your entire identification number (with the three-letter prefix) when you call or write. Anthem will respond to most questions or requests at the time of your call or within a few days. Please see subsection II (below) for complete information about the internal appeal procedure

If you have a concern about the quality of care offered to you in the network (such as waiting times, physician behavior or demeanor, adequacy of facilities or other similar concerns), you are encouraged to discuss the concerns directly with the provider before you contact a Customer Service Representative.

Prescription Drug List Exceptions

To request an exception for drugs not on the prescription drug list, please see your Network Pharmacy Rider, section II "Prior Authorization."

<table>
<tr><td>Please contact Anthem's Customer Service Center about your membership, Benefits, Covered Services, plan materials, the network or Network Providers. Anthem's toll-free telephone number is 1-800-870-3122.</td><td>Or, you may write to:
Customer Service Center
Anthem Blue Cross and Blue Shield
P.O. Box 660
North Haven, CT 06473-0660</td></tr>
<tr><td colspan="2">For more information about Member services, please visit Anthem's website at www.anthem.com.</td></tr>
</table>

II. Appeal Procedure

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims. Please see Section 14 for a definition of "Claim Denial," "Pre-Service Claim" and "Post-Service Claim."

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

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

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

Notice of Adverse Benefit Determination
If your claim is denied, Anthem's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which Anthem's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision;
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you; and
- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- Anthem's notice will also include a description of the applicable urgent/concurrent review process; and
- Anthem may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals
You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Anthem's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

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

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

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

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

Appeals Department
Anthem Blue Cross and Blue Shield
P.O. Box 518
North Haven, CT 06473-0518

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

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

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

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

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

Notification of the Outcome of the Appeal

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

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

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

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

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

External Review
If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to Anthem within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless Anthem 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 Anthem's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact Anthem 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 Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Appeals Department
Anthem Blue Cross and Blue Shield
P.O. Box 518
North Haven, CT 06473-0518

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

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

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

III. Disagreement With Recommended Treatment

Your physician is responsible for determining the health care services that are appropriate for you. You may disagree with your physician's decisions and you may decide not to comply with the treatment that is recommended by your physician.

You may also request services that your physician feels are incompatible with proper medical care. In the event of a disagreement or failure to comply with recommended treatment, you have the right to refuse the recommendations of your physician. In all cases, Anthem has the right to deny Benefits for care that is not a Covered Service or is not Medically Necessary as defined in this Certificate or is otherwise not covered under the terms of this Certificate.

SECTION 12: GENERAL PROVISIONS

Please see Section 14 for definitions of specially capitalized words.

Limitations or Exclusions. This Certificate shall be construed so that a specific limitation or exclusion will override more general Benefit language.

Right to Change the Certificate. No person or entity acting on behalf of Anthem agent has the right to change or waive any of the provisions of this Certificate without the approval of Anthem's chief executive in New Hampshire.

- **Waiver of Certificate Provisions.** Neither the waiver by Anthem hereunder of a breach of or a default under any of the provisions of this Certificate, nor the failure of Anthem, on one or more occasions, to enforce any of the provisions of this Certificate or to exercise any right or privilege hereunder, will thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any of such provisions, rights or privileges hereunder.

- **Applicable Law.** This Certificate, the rights and obligations of Anthem and Members under this Certificate, and any claims or disputes relating thereto, will be governed by and construed in accordance with the laws of New Hampshire. This Certificate is intended for sale in the State of New Hampshire. Your Certificate is intended at all times to be consistent with New Hampshire law. If New Hampshire laws, regulations or rules require Anthem to provide Benefits that are not expressly described in this Certificate, then this Certificate is automatically amended only to the extent specified by the laws, regulations or rules that are enacted by the State of New Hampshire. Anthem may adjust premium requirements to reflect additional Benefit requirements that are mandated by the State of New Hampshire.

Anthem is not Responsible for Acts of Providers. Anthem is not liable for the acts or omissions by any individuals or institutions furnishing care or services to you.

Reservation of Discretionary Authority. Anthem, or anyone acting on Anthem's behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on Anthem's behalf, have complete discretion to determine the administration of your benefits. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Anthem's decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures. The appeal process is stated in Section 11 of this Certificate.

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

Limitation on Benefits of This Certificate. No person or entity other than Anthem and Members hereunder is or will be entitled to bring any action to enforce any provision of this Certificate against Anthem or Members hereunder, and the covenants, undertakings and agreements set forth in this Certificate will be solely for the benefit of, and will be enforceable only by, Anthem and the Members covered under this Certificate.

Headings, Pronouns and Cross-References. Section and subsection headings contained in this Certificate are inserted for convenience of reference only, will not be deemed to be a part of this Certificate for any purpose, and will not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

All pronouns and any variations thereof will be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

In this Certificate, you find "cross-references." For example, Section 7, "Covered Services" often refers to Section 8, "Limitations and Exclusions." These cross-references are for your convenience only. Cross-references are not intended to represent all of the terms, conditions and limitations set forth in this Certificate.

Spendthrift Provision. The rights to receive Benefits under this health care plan shall not be assignable or subject to attachment or receivership, nor shall it pass to any trustee in bankruptcy or be reached or applied by any legal process.

Subcontracting. Anthem may subcontract with specialized organizations or entities to administer portions of this health plan. For example, administration of Anthem's pharmacy Benefits or Behavioral Health Care Benefits may be managed by a Subcontractor selected by Anthem. Subcontractors may make Benefit determinations and/or perform administrative, claims paying, or customer service duties on Anthem's behalf.

Voluntary Wellness Incentive Programs. Anthem may offer health or fitness related program options for purchase by your Group. If your Group has selected this option, 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. (Use of gift cards for purposes other than for qualified medical expenses may result in taxable income to you. For additional guidance, please consult your tax advisor.) These programs are not Covered Services under this certificate, but are a value added component of your plan benefits. These program features are not guaranteed under this certificate and could be discontinued at any time.

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

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

SECTION 13: MEMBERSHIP ELIGIBILITY, TERMINATION OF COVERAGE AND CONTINUATION OF COVERAGE

Please see Section 14 for definitions of specially capitalized words.

I. Eligibility

By accepting this Certificate, you agree to give Anthem information that Anthem needs to verify coverage eligibility. Examples of documentation that Anthem may need to decide membership eligibility are: information regarding residency (such as, but not limited to voter registration and vehicle registration or property tax verification), dependent child status, marital status, divorce, legal separation, birth, adoption or court orders regarding health care coverage for your dependent children and verification of your employment status.

Who Is Covered Under This Certificate? You, the Subscriber, are covered under the Certificate. Depending on the type of coverage you selected ("family," "two person," or "parent and child"), the following members of your family are also covered:

A. Your Spouse . Your spouse is eligible to enroll unless you are legally separated. Throughout this Certificate, any reference to "spouse" means:

- The individual to whom the Subscriber is lawfully married, as recognized under federal or state law, and
- The individual with whom the Subscriber has entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

Throughout this Certificate any reference to "marriage" means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a lawful marriage or lawful civil union.

The Subscriber's ex-spouse, following legal separation or divorce is not eligible to enroll. Please note that a covered spouse whose coverage would otherwise end due to legal separation or divorce may elect to continue coverage as stated in subsection III "Continuation of Coverage."

B. **Dependent children.** A dependent child is a Subscriber's child by blood or by law who is under age 26. Dependent children are your natural children, legally adopted children, children for whom you are the legal guardian, stepchildren and children for whom you are the proposed adoptive parent and who have been placed in your care and custody during the waiting period before the adoption becoming final. Foster children and grandchildren are not eligible for coverage unless they meet the definition of a dependent child stated in this subsection.

Membership ends for a covered dependent child on the earlier of:

- The date that any of the eligibility conditions listed above cease to be met, or
- The date upon which the Group ceases to provide coverage to the Subscriber.

C. **EXCEPTION: Incapacitated Dependents.** Incapacitated Dependents are the Subscriber's dependent children who are 26 years old or older and who are mentally or physically incapable of earning their own living on the date that eligibility under this Certificate would otherwise end due to age. Incapacitated dependents may remain covered as long as their disability continues and as long as they are financially dependent on the Subscriber and are incapable of self-support. Anthem must receive an application for this incapacitated status, and medical confirmation by a physician of the extent and nature of the disability, within 31 days of the date coverage would otherwise end.

Anthem's Medical Director must certify that your child is incapacitated. Anthem may periodically request that the incapacitated status of your child be recertified. If the child's disability ends, he or she may elect to continue group coverage as stated in subsection III "Continuation of Coverage," (below).

Except as stated below under "When Coverage Begins," "Special Enrollees," and "Newborn Children", membership *changes* become effective on the date your Group renews its annual agreement with Anthem or on a general Group reopening date or on another date determined by an agreement between your Group and Anthem, provided that a completed enrollment application is received by your Group and Anthem at least 30 days before the effective date (or within a time frame determined by an agreement between your Group and Anthem).

When Coverage Begins. Your coverage begins on the effective date determined by your Group. You should contact your Group Benefits Administrator for information about your effective date. Your Group may require an initial enrollment Waiting Period to new Subscribers and their dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the Waiting Period chosen by the Group. By law, a Waiting Period will not exceed 90 days. If you do not enroll yourself and/or your dependents during the initial enrollment period you will only be able to enroll during your Group's annual open enrollment period or as a Special Enrollee. For complete information about Special Enrollees, please see "Special Enrollees" (below).

If you are already enrolled, coverage begins for new members of your family on the date they meet the definitions described in this subsection, provided Anthem receives an application within 31 days of eligibility. Otherwise, you must wait until your Group's next open enrollment period to add the eligible dependent, except as below for "Special Enrollees."

If you return from full-time active service following a call to active military duty, no Waiting Period applies (a Waiting period is a period of time, if any, that a Group ordinarily requires to pass before the Group's health plan becomes effective. See Section 14 for the definition). You and eligible family members can reenroll in your Group's health care plan, provided you apply for reemployment within the time period permitted by the Uniformed Services Employment and Reemployment Act (USERRA). The time period allowed for reemployment depends on the length of your active military duty. To reenroll in your Group's health care plan, your application must be received within 31 days of your reemployment date. Coverage will be effective on the effective date of your reemployment.

Special Enrollees. Ordinarily, employees and eligible dependents who fail to enroll when first eligible cannot enroll until the Group's subsequent annual renewal date, a general Group reopening or a date determined by an agreement between the Group and Anthem. Exceptions exist for Special Enrollees as described below. Special Enrollees are employees and/or eligible dependents who did not enroll in a Group's health care plan (such as the health care plan provided under this Certificate) when first eligible and who experience one of the following events:

- **Loss of eligibility for other coverage.** This event applies when an employee or an eligible dependent loses other public or private health care coverage, provided that the person was covered under the other plan at the time he or she was first eligible to enroll in this plan and he or she declined enrollment in this plan when first eligible. Provided that your Group and Anthem receives a completed enrollment form within 30 days after eligibility for other coverage is lost, this Certificate will become effective on the first day of the month after receipt of the enrollment form. EXCEPTION to the 30-day rule: Please see "Loss of eligibility for coverage under a state Medicaid or child health insurance program" below

  ***Please note:* "loss of eligibility for other coverage" includes the following events:**

  - Voluntary or involuntary termination of the other health care coverage (including exhaustion of coverage under continuation laws, such as COBRA and whether or not such continuation options exist),

  - Loss of eligibility due to voluntary or involuntary termination of employment or eligibility,

  - Loss of eligibility due to a reduction in work hours,

- Loss of eligibility due to legal separation, divorce, the death of a spouse or a dependent otherwise loses eligibility (for example: a child attains an age that causes him or her to lose eligibility status in another plan, but the child is eligible to enroll in this health care plan),

- Employer contributions toward the other coverage end (regardless of whether the person is still eligible for the other coverage),

- For a person covered under an individual HMO policy that does not provide benefits to individuals who no longer reside, live or work in the Service Area, loss of eligibility occurs when the individual loses coverage because he or she no longer resides, lives or works in the service area. For a person with group HMO coverage, the same rule applies, provided that there is no other coverage offered by the other health care plan,

- Loss of eligibility because the other plan ceases to offer health care benefits to a class of similarly situation individuals,

- In a multiple-option group plan, an issuer or insurer providing one of the options ceases to operate in the group market (exception: this provision does not apply if the group plan provides a current right to enroll in alternative coverage),

- An individual incurs a claim that meets or exceeds the other plan's lifetime benefit maximum.

- The employee's or eligible dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility. Provided that your enrollment process is completed within 60 days after the eligibility is determined, this Certificate will become effective on the first day of the month after receipt of the enrollment form.

- **Court ordered enrollment.** This event applies when a court has ordered coverage for a spouse or dependent child under an employee's health care plan. Provided that your Group and Anthem receive a completed enrollment form within 30 days after the court order is issued, this Certificate will become effective on the first day of the month after receipt of the enrollment form.

- **New dependent due to marriage or civil union.** Employees and eligible dependents who are not covered under this health plan may enroll due to lawful marriage or lawful civil union at the same time as the new spouse. Provided that your Group and Anthem receive a completed enrollment form within 30 days of the date of marriage or civil union, this Certificate will become effective on the first day of the month after receipt of the enrollment form.

- **Eligibility for a state premium assistance program under Medicaid or CHIP.** Employees and/or spouses and other eligible dependents who are not covered under this health plan may enroll when the employee or the spouse or an eligible dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or the Children's Health Insurance Program (CHIP). Provided that your enrollment process is completed within 60 days after the eligibility is determined, this Certificate will become effective on the first day of the month after receipt of the enrollment form.

New dependent due to birth, adoption or placement for adoption. Employees and/or spouses and other eligible dependents who are not covered under this health plan may enroll at the same time as a newborn child, adopted child or a child placed in your home as the adoptive parent during the waiting period before adoption. Provided that your Group and Anthem receive a completed enrollment form within 30 days of the birth, adoption or placement, this Certificate will become effective on the date of the birth, adoption or placement.

Newborn Children. Your newborn child is eligible for Benefits described in this Certificate for up to 31 days from the child's date of birth, as long as your coverage is in effect during that time. However, you must complete an enrollment form to add the child to your membership as a covered dependent child. The enrollment form must show your child's name and date of birth. If you do not have a "family" type membership when your child is born, you must also indicate on the enrollment form that you want to change your type of membership (from "two person" to "family" or from "one person" to "parent/child" or "family"). You can obtain an enrollment form from your

employer. To maintain continuous coverage for your newborn, Anthem must receive your enrollment form within 31 days of the child's birth.

- If your enrollment form is received within 31 days of the child's birth, your change in membership type will become effective on the first day of the month following the child's date of birth. If your enrollment form is not received by Anthem within 31 days after birth, your child's eligibility for Benefits will end at midnight on the 31st day after the date of birth and you will not be able to enroll your child until your Group's next open enrollment period.

- If your covered dependent child or Student gives birth, your newborn grandchild is eligible for Benefits for up to 31 days from the child's date of birth. You cannot add the grandchild to your membership unless you adopt or become the legal guardian of the grandchild.

Effective Date for Benefits. The effective date of the Benefits described in this Certificate is determined by your Group. After your coverage under this Certificate begins, Benefits are available according to the coverage in effect on the "date of service."

- For Inpatient hospital *facility* charges, the date of Inpatient admission is the date of service. However, for Inpatient *professional* services (such as Inpatient medical care or surgery furnished by a physician), the date of service is the date you receive the care.

- For professional maternity care (prenatal care, delivery of the baby and postpartum care), the date of service is the date of delivery, provided that the total maternity care was furnished by one provider.

- For Outpatient services (such as emergency room visits, Outpatient hospital care, office visits, physical therapy or Outpatient surgery, etc.), the date of service is the date you receive the care.

Persons Not Eligible for Membership. You must meet the eligibility rules of your Group and the terms set forth by Anthem in this Certificate to be eligible for membership.

Membership will not be denied solely due to medical risk factors such as health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability, sexual orientation or identity, gender, or evidence of insurability (including conditions arising out of domestic violence).

Your Responsibility to Notify Anthem About Changes. It is your responsibility to inform your Group and Anthem of changes in your name or address. It is also your responsibility to inform your Group and Anthem if you need to add a Member to your coverage or when a Member is no longer eligible for coverage under your Certificate. Notice requirements regarding continuation coverage election are stated in subsection III, below.

Name changes and membership changes must be made through your Group Benefits Administrator. You will be required to sign an enrollment form in order to effect the change. You can mail notices about a change of address to:

Anthem Blue Cross and Blue Shield
P.O. Box 660, North Haven, Connecticut 06473-0660

Please include your identification number (shown on your identification card) whenever you correspond with Anthem.

Disclosing Other Coverage. As another condition of membership, you agree to provide information to Anthem regarding any other health coverage under which you may be entitled to Benefits. Your receipt of Benefits through another health care plan may affect your Benefits under this Certificate. If you or any of your dependents become eligible for Medicare, contact your Group Benefits Administrator and Anthem immediately. Please see Section 10 for more information about how Benefits are determined when you are covered under more than one health insurance plan, including Medicare.

II. Termination of Coverage

For purposes of this subsection, "you" refers to the Subscriber. Whether the Subscriber or the Group contacts Anthem to effect any of the termination events listed in this subsection, Anthem will administer the terminations if Anthem has knowledge of the qualifying event.

Membership will not be terminated solely due to medical risk factors such as health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability, sexual orientation or identity, gender, or evidence of insurability (including conditions arising out of domestic violence).

PLEASE SEE SUBSECTION III, BELOW FOR INFORMATION ABOUT HOW TO CONTINUE GROUP COVERAGE AFTER COVERAGE WOULD OTHERWISE END.

Termination or Renewal of the Group Contract. Coverage under this Certificate is provided under the terms of a contract between Anthem and the Group. The Group agreement is effective for a fixed term. At the time of your Group's anniversary date or at a special open enrollment period agreed upon by Anthem and your Group, Anthem will renew the Group agreement at the option of your Group, except for the following reasons:

- Nonpayment of required premiums. Coverage will terminate on a date stated in a notice mailed by Anthem to the Group if Anthem does not receive payment on time from the Group. Cancellation for nonpayment is considered cancellation by the Group and Subscriber, and not by Anthem.

- The Group's failure to meet Anthem's minimum employee participation requirements. Notice of cancellation or nonrenewal for failure to meet minimum participation requirements will be delivered to the Group by Anthem, (or mailed to the Group's most current address, as shown on Anthem's records) at least 30 days before the effective date of the cancellation or nonrenewal.

- Fraud or intentional misrepresentation on the part of an individual or an individual's representative or on the part of an employer, employee, dependent or an employee's representative.

- The employer restricts eligibility to participate in the plan based on an applicant's medical history or otherwise violates applicable law regarding medical underwriting, such as New Hampshire law and federal HIPAA regulations,

- Anthem ceases to offer coverage in the large employer market, and has provided 180 days prior notification to the New Hampshire Insurance Department of such action and is otherwise in accordance with all of the terms and conditions of New Hampshire law regarding such action.

Except for nonpayment of premium and as otherwise stated above, any notice of cancellation or nonrenewal will be delivered to the Group by Anthem or mailed to the Group's most current address, as shown on Anthem's records. Upon termination of the Group contract, no further Benefits will be provided under this Certificate, except as described in subsection III (below).

If You Are No Longer a Member of the Group. If your employment or membership in the Group terminates, your coverage will terminate on a date as determined by your Group and Anthem. Please see subsection III (below) for information about continuing group coverage.

On Your Death. Your coverage will terminate on the date of your death. Please see subsection III (below) for information about how covered surviving spouses and covered dependents can elect to continue group coverage following the death of the Subscriber.

Termination of Your Marriage. If you become divorced or legally separated, your former spouse is eligible to continue Group coverage only as stated in subsection III, (below).

Termination of a Dependents' Coverage. A Dependent child's coverage or an Incapacitated Dependent's coverage under this Certificate will terminate on the first day of the month following date on which the dependent no longer meets the eligibility requirements stated in I "Eligibility," B "Dependent children" and C "EXCEPTION: Unmarried Incapacitated Dependents." The Subscriber must submit an enrollment form indicating the change within 30 days of such change.

Other Situations Under Which This Coverage May Terminate - Anthem may terminate coverage under this certificate for one of the following reasons:

- Anthem may not renew a Subscriber's coverage for fraud committed by the Subscriber or Member in connection with information provided with any claim filed for Benefits.

- Anthem may not renew a Subscriber's coverage upon 30 days advance written notice if an unauthorized person is allowed to use any Member's identification card or if the Subscriber or Member otherwise cooperates in the unauthorized use of such Member's identification card.

The Subscriber and any applicant age 18 or older represent that all statements made in his or her enrollment form for membership, and any enrollment forms or enrollment processes for membership of dependents, are true to the best of his or her knowledge and belief. If a Subscriber furnishes any misleading, deceptive, incomplete, fraudulent or untrue statement which is material to the acceptance of his or her enrollment, Anthem may terminate his or her enrollment under this health plan (and that of his or her spouse and dependents), provided that the termination action occurs within two years from the Subscriber's date of enrollment. No statement made, for the purpose of obtaining coverage, will void coverage unless it is written in the enrollment form and signed by you, the Subscriber.

Rescission. Anthem may terminate a Member's coverage back to the original effective date for fraud or intentional misrepresentation of a material fact on the part of a covered person. The Subscriber and any applicant age 18 or older represent that all statements made in the enrollment forms and those of dependents are true to the best of their knowledge and belief. Any act or practice that constitutes fraud or an intentional misrepresentation of material fact may cause Anthem to terminate a Member's coverage back to the original effective date, provided that the rescission occurs within two years from the Subscriber's date of enrollment.

III. Continuation of Coverage

This section explains the options available to you for continuing your Group coverage after the coverage would otherwise end. There may be other coverage options for you and your family through the Health Insurance Marketplace (www.HealthCare.gov). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for continuation coverage under federal or state regulations does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Continuation Laws. Certain provisions of law affect your rights to continue coverage when group coverage would otherwise end. Examples of such laws are state statutes and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). In general, federal COBRA law applies if your employer had an average of 20 or more benefit-eligible employees during the year. If you have any questions about continuation of group coverage under New Hampshire laws or federal laws, please contact your Group Benefits Administrator immediately.

A. **Continuation for Divorce or Legal Separation.** If you and your spouse are divorced or legally separated while you are a member of a Group Health Plan, your former spouse is eligible to remain on your policy, as an active dependent until the earliest of the following events occurs:

- Remarriage of the Subscriber;

- Remarriage of the former spouse;

- Death of the Subscriber;
- The 3-year anniversary of the final decree of divorce or legal separation; or
- Such earlier time as provided by the final divorce decree or legal separation

NOTE: If the covered divorced or legally separated spouse is 55 years old or older, the former spouse may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after the date of the divorce or legal separation, *whichever occurs first.*

When one of the above events occurs, your Group Benefit Administrator must notify Anthem of your former spouse's ineligibility. Your former spouse may be eligible under the State of New Hampshire Continuation provisions described in B, below.

If your Group replaces this coverage with another insurance carrier, your former spouse may be eligible to continue as your active dependent under the replacement policy. Please consult with the replacement carrier for complete information.

B. Continuation of Coverage under COBRA. Please Contact your Group Benefits Administrator for complete information about continuation of group coverage under COBRA (federal) regulations. The following is an outline of your COBRA rights and responsibilities.

If your employment is terminated for any reason (except for gross misconduct) or your hours of employment are reduced so that you do not qualify to participate in your employer health care plan, you and your covered dependents may continue your health care Benefits for as long as 18 months.

Any qualified beneficiary may continue COBRA coverage for a period of 18 to 29 months if you are disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time before or within the first 60 days of the initial 18-month period of COBRA coverage. In order to qualify for the extension, you must notify the Plan Administrator, in writing, of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. During a period of COBRA continuation, nondisabled family members who are covered under the same Certificate as the disabled Member are also entitled to the 29 month disability extension.

If coverage ends because of your death, your covered dependents may continue group coverage for as long as 36 months. Your covered spouse may continue group coverage for as long as 36 months if coverage would otherwise terminate by divorce or legal separation or because you become entitled to Medicare Benefits. Your dependent children may continue group coverage for as long as 36 months if coverage would otherwise cease because they fail to meet the Anthem definition of dependent child.

A child who is born to the covered employee during a period of COBRA continuation is a qualified beneficiary. A child who is placed for adoption with the covered employee during a period of COBRA continuation is a qualified beneficiary. Please complete an Enrollment Application to add your newborn or adopted child to your COBRA continuation coverage and return the form to your Group Benefits Administrator.

If a continuing beneficiary becomes entitled to Medicare Benefits, then a qualified dependent beneficiary (other than the Medicare beneficiary) is entitled to continuation coverage for no more than a total of 36 months.

These Benefits terminate if:

- A continuing beneficiary fails to pay a required premium on time, or
- The employer or insurer terminates all Benefits under its employee welfare benefit plan for all employees, or

- A continuing beneficiary becomes covered under enrolled another group health plan or entitled to Medicare benefits after he or she elects COBRA. Entitlement to Medicare means being enrolled in Medicare Part A or B or in a Medicare Select or Medicare+Choice program. Please note: If a continuing beneficiary becomes enrolled in another group health care plan, coverage may continue only if the new group health plan contains preexisting condition exclusions or limitations and may continue only until such limitations cease.

In the event you become ineligible for coverage in your employer health plan, you must notify your Group Benefits Administrator within 30 days. You must notify the Group Benefits Administrator within 60 days of the date of your divorce or legal separation and within 60 days of the date your enrolled dependent(s) no longer meet Anthem's definition of a dependent. The employer or his administrator must notify qualified beneficiaries of their rights to continue coverage within 14 days.

You or an eligible family Member must decide to continue coverage within 60 days of the date your coverage would otherwise end or the date your employer notifies you of this right, whichever is later. You must pay the total premium appropriate for the coverage you choose to continue. The premium you pay cannot be more than 102 percent of the premium charged for employees with similar coverage and it must be paid to your employer within 30 days of the date due, except that the initial premium payment must be made within 45 days after the initial election for continuation of coverage or your continuation rights will be forfeited.

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

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

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

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

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

SECTION 14: DEFINITIONS

This Section defines some of the words and phrases found throughout this Certificate :

Adverse Determination means a decision by Anthem (or by a designated clinical review entity of Anthem, that a scheduled or emergency admission, continued stay, availability of care, or other health care service has been reviewed and does not meet Anthem's definition of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Therefore, Benefits are denied, reduced or terminated by Anthem.

Behavioral Health Care means Covered Services provided to treat Mental Disorders and Substance Abuse Conditions as defined in Section 7, V.

Benefits means reimbursement or payments available for Covered Services, as described in this Certificate.

Birthing Center means an Outpatient facility operating in compliance with all applicable state licensing and regulatory requirements for Birthing Centers. The primary function of a Birthing Center is to provide Outpatient facility services for prenatal care, delivery of a baby and postpartum care for a mother and her newborn. To be eligible for Benefits under this Certificate, a Birthing Center must have a written agreement directly with Anthem or with another Blue Cross and Blue Shield plan to provide Covered Services to Members. Otherwise, no Benefits are available for services furnished by a Birthing Center.

BlueCard Provider means a Designated Provider outside New Hampshire that is not a Network Provider, but has a written payment agreement with the local Blue Cross and Blue Shield Plan.

Calendar Year means a period of time that starts on January 1 and ends on December 31 of any given year.

Certificate means the agreement between a Subscriber and Anthem regarding the terms and limitations of coverage under this managed health care plan. The Certificate includes the Subscriber Certificate (this document), your completed enrollment form (including an electronic enrollment process), your identification card, your Cost Sharing Schedule and any endorsements and/or riders that amend the Subscriber Certificate.

Claim Denial means any of the following: Anthem's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a member's eligibility for coverage under this Certificate. Claim Denial also includes Anthem's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of utilization review procedures, as well as failure to cover a service for which benefits are otherwise provided based on a determination that the service is Experimental, Investigational or not Medically Necessary or appropriate.

Contract Year means a period of time that begins on the effective date of the health care plan offered by your Group through its agreement with Anthem. The first contract year ends the day before your Group's first annual renewal date. Each subsequent contract year begins on your Group's annual renewal date and ends the day before its next annual renewal date.

Contracting Provider means a Designated Provider that has an agreement with Anthem to provide certain Covered Services to Members. A Contracting Provider is not a Network Provider.

Convenience Services Please see Section 8, II "Exclusions" for a definition of "Convenience Services."

Covered Service means the services, products, supplies or treatment specifically described as being eligible for Benefits in this Certificate. To be a Covered Service the service, product, supply or treatment must be:

- Medically Necessary or otherwise specifically described as a Covered Service under this certificate, and
- Within the scope of the license of the Designated Provider performing the service, and
- Rendered while coverage under this Certificate is in force, and

- Not Experimental or Investigational or otherwise excluded or limited under the terms of this Certificate, or by any endorsement, rider or amendment to this Certificate.

- The plan rules stated in this Certificate and in any amendment to this Certificate, must be met. Otherwise, a service may not be a Covered Service. Plan rules include, but are not limited to, rules such as those pertaining to services furnished by Network Providers and requirements about Precertification or Preauthorization from Anthem.

Designated Network means a group of PCPs, hospitals, facilities, specialists, suppliers and any other health care practitioners all having a written agreement directly with the same affiliated New England Blue Cross and Blue Shield Plan to provide Covered Services to Members.

Designated Provider means the following health care providers, each being duly licensed or certified as required by law in the state which regulates their licensure and practice and each acting within the scope of the applicable license or certification: Short Term General Hospitals, Skilled Nursing and Physical Rehabilitation Facilities, facilities for laboratory and x-ray tests and screenings, individuals licensed and certified to interpret laboratory and x-ray tests and screenings, ambulatory surgical centers that have a written payment agreement with Anthem or the Blue Cross and Blue Shield plan where the center is located, hemodialysis centers, home dialysis providers and birthing centers that have a written payment agreement with the Anthem or the Blue Cross and Blue Shield plan where the birthing center is located, and cardiac rehabilitation programs. Physicians include Doctors of Medicine (MDs) and Advanced Practice Registered Nurses (APRNs) acting within the scope of their licenses. Designated Providers also include physician assistants, nurses and nurse-anesthetists. Home health, hospice and visiting nurse association providers and their certified staff members are also Designated Providers. Infusion therapy providers, licensed durable medical equipment, medical supply or prosthetic providers, licensed retail pharmacies, designated licensed mail order pharmacies, licensed ambulance transportation providers, physical, occupational and speech therapists, doctors of osteopathy and doctors of podiatry are Designated Providers. Audiologists, optometrists, nutrition counselors, Network Diabetes Education Providers, Eligible Behavioral Health Providers, Network New Hampshire Certified Midwives (Network NHCMs), dentists and oral surgeons are Designated Providers only to the extent of coverage stated in Section 7 in this Certificate. Except at the sole discretion of Anthem, no other provider is a Designated Provider. For example, Doctors of Chiropractic are Designated Providers only to the extent stated in Section 7. Practitioners such as acupuncturists, electrologists, doctors of naturopathic medicine and any provider of alternative or complimentary medicine are not Designated Providers. School infirmaries are not Designated Providers. Except as specified in Section 7 of this Certificate, as required by law or by exception at Anthem's discretion, Benefits are available only when Covered Services are:

- Furnished by a physician, most often your Network Provider, or

- Ordered by a physician (most often your Network Provider) and furnished by a Designated Provider.

Developmental Disabilities means chronic mental or physical impairments that occur at an early age, are likely to continue indefinitely, result in substantial functional limitations and require special care and services of lifelong or extended duration. Such disabilities include, but are not limited to, abnormalities of the neurological and musculoskeletal systems due to congenital chromosomal anomalies or perinatal disorders, any of which may cause mental retardation or delays in mental development as well as abnormalities or delays in motor functioning and development.

Enrollment Date means the first day of coverage under the plan, or, if there is a Waiting Period established by your Group, the first day of the Waiting Period, which is typically the first day of work.

Group means an organization (such as a large employer, small employer, qualified association trust as defined by law and/or a licensed purchasing alliance as defined by law) to which you belong, that arranges for your coverage described in this Certificate.

Group Benefits Administrator means the person at your company or place of employment who handles health benefits for your Group.

Home Health Agency means a state authorized and licensed agency or organization that provides nursing and therapeutic care in the home of the Member. It must maintain permanent records of services provided to its patients, employ a full-time administrator and have at least one Registered Nurse (R.N.) either on the staff or available to it.

Inpatient means care received while you are a bed patient in a hospital, Skilled Nursing Facility or Physical Rehabilitation Facility.

Local Plan means the affiliated New England Blue Cross and Blue Shield plan that administers written agreements made directly between the Local Plan and Network Providers in a Designated Network.

Maximum Allowable Benefit means the dollar amount available for a specific Covered Service. Anthem determines the Maximum Allowable Benefit for approved Covered Services that you receive in New Hampshire. Anthem also determines the Maximum Allowable Benefit for approved Covered Services that you receive from a NonBlueCard Provider outside New Hampshire. The Local Plan determines the Maximum Allowable Benefit for Covered Services furnished by a BlueCard Provider. Network Providers and BlueCard Providers accept the Maximum Allowable Benefit as payment in full.

Medical Director means a physician licensed under New Hampshire law, employed by Anthem is responsible for Anthem's utilization review techniques and methods and their administration and implementation.

Medically Necessary or "Medical Necessity" means health care services or products provided to an enrollee for the purposes of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

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

Please note: The fact that a Designated Provider or other health practitioner orders, prescribes, recommends or furnishes health care services or products will not cause the intervention to be automatically considered Medically Necessary. Anthem may consult the Medical Director and/or independent medical specialists, peer review committees, or other health care professionals qualified to make a recommendation regarding the Medical Necessity of any service or product prescribed for a Member.

You have the right to appeal Benefit determinations made by Anthem or its delegated entities, including Adverse Determinations regarding medical necessity. Please refer to the appeal process in Section 11 of this Certificate for complete information.

Member means a Subscriber and any spouse or lawful civil union partner of a Subscriber. "Member" also means any individual who is covered under this Certificate and is the eligible dependent of the Subscriber, the Subscriber's spouse or the Subscriber's lawful civil union partner.

Network Behavioral Health Provider means a hospital or other Eligible Behavioral Health Provider, as defined in Section 7, V who has an agreement with Anthem or with another Local Plan to make Covered Behavioral Health Care (Mental Health and Substance Abuse) care available to Members.

Network Birthing Center means a Birthing Center, as defined above in this Section, that has a written agreement directly with Anthem or another Local Plan to provide Covered Services to Members.

Network Diabetes Education Provider means a certified, registered or licensed health care expert in diabetes management who has a written agreement directly with Anthem to furnish diabetes counseling and diabetes education to Members.

Network New Hampshire Certified Midwife (NHCM) means an individual who is certified under New Hampshire law and who has a Network written agreement directly with Anthem to provide Covered Services to Members.

Network Nutrition Counselor means a registered dietitian practicing independently or as part of a physician practice or hospital clinic and who has a written agreement directly with Anthem or with another Local Plan to provide nutrition counseling to Members.

Network Primary Care Provider (PCP) means a Network Provider who has a written agreement with Anthem or another Local Plan regarding, among other things, willingness to provide Covered Services to Members as a Primary Care Provider.

Network Provider means any Designated Provider (such as, but not limited to: physicians, specialists, health care professionals, health care practitioners or hospitals) that has a Network *w*ritten payment agreement with Anthem or with their Local Plan to provide Covered Services to Members**. Network Physicians** include Doctors of Medicine (MDs) and Advanced Practice Registered Nurses (APRNs) acting within the scope of their licenses.

Network Service means a Covered Service that you receive from a Network Provider.

Network Walk-In Center means a free-standing center that has a written payment agreement directly with Anthem or with the Local Plan to provide health services without appointments for diagnosis, care and treatment of urgent illness or injury.

NonBlueCard Provider means a Designated Provider outside New Hampshire that does not have a written payment agreement with their local Blue Cross and Blue Shield plan.

Out-of-Network Provider means any physician, specialist, health care professional, health care practitioner, pharmacy, hospital or other health care facility or Designated Provider that is not a Network Provider. Providers who have not contracted or affiliated with Anthem's designated Subcontractor(s) for the services that are Covered Services under this Certificate are also considered Out-of-Network Providers.

Out-of-Network Services means Covered Services that you receive from an Out-of-Network Provider.

Outpatient means any care received in a health care setting other than an Inpatient setting. "Inpatient" is defined above.

Physical Rehabilitation Facility means a state authorized and licensed facility for physical rehabilitation services where short-term active professional care is provided.

Post-Service Claims means any claim for a health benefit to which the terms of the plan do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care. "Post-service claim" shall not include a request for reimbursement made by a provider pursuant to the terms of an agreement between the provider and Anthem.

Precertification or "Precertify" Anthem's or the Local Plan's written confirmation that a service is Medically Necessary. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including but not limited to, Copayment, Deductible, Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

Pre-Service Claims means any claim for a benefit under a health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. "Pre-service claim" shall not include a request for reimbursement made by a provider pursuant to the terms of an agreement between the provider and Anthem.

Referral means a specific written recommendation by a Member's PCP or Network Provider that the Member should receive evaluation or treatment from a specific Designated Provider. A recommendation from a PCP or Network Provider is a Referral only to the extent of the specific services approved by the PCP or Network Provider on the written Referral form or by other notification methods prescribed by Anthem or a Local Plan for use by PCPs and

Network Providers. A general statement by a PCP or Network Provider that a Member should seek a particular type of service or provider does not constitute a Referral under this Certificate.

Service Area means the geographic area within which all Designated Networks combined are located.

Short Term General Hospital means a health care institution having an organized professional and medical staff and Inpatient facilities that care primarily for patients with acute diseases and injuries with an average patient length of stay of 30 days or less.

Skilled Nursing Facility means an institution which is, pursuant to law, in compliance with all applicable state licensing and regulatory requirements and which provides room and board accommodations and 24-hour-a-day nursing care under the supervision of a Physician and/or Registered Nurse (R.N.) while maintaining permanent medical history records.

Subcontractor. Anthem may subcontract particular services to organizations or entities called Subcontractors having specialized expertise in certain areas. This may include but is not limited to mental health and/or substance abuse care. Such Subcontractors or subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, or customer service duties on behalf of Anthem.

Subscriber means you, the Member to whom this Certificate is issued.

Urgent Care Claim means any request for Precertification submitted as required under this Certificate, for care or treatment with respect to which the application of time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the proposed care or treatment.

Urgent Care Facility means a licensed hospital's free-standing facility that provides urgent health services for diagnosis, care and treatment of illness or injury. Please see Section 6, "Urgent and Emergency Care" for more information about urgent care.

Waiting Period means the period of time, if any, that must pass between the Enrollment Date (defined above in this Section) and the date that coverage under your Group's health plan becomes effective. Waiting Periods are established by your Group and apply when employees and their eligible dependents are first eligible to enroll in the Group's health plan. For example: An individual is hired on January 1. The Group requires a three-month Waiting Period before the new employee's health coverage becomes effective. The Enrollment Date is January 1. The Waiting Period is the three-month period between January 1 and April 1. On April 1, the Waiting Period ends and the employee's health plan coverage becomes effective.

Walk-In Center means a free-standing center providing health services without appointments for diagnosis, care and treatment of urgent illness or injury.

You, Your and Yours - Unless specifically stated otherwise, the words "you," "your" and "yours" refer to you, the person to whom this Certificate is issued (the Subscriber) and your covered spouse and covered dependents-collectively the Members.

Anthem BlueCross BlueShield

Network Pharmacy Rider

This rider amends your Subscriber Certificate. It is part of your Certificate. Except as stated in this rider, all of the terms of your Certificate apply.

I. Covered Services

Benefits are available for prescription drugs purchased at a Network Pharmacy or Network Specialty Pharmacy. Covered Services must be ordered in writing, by telephone or electronically by a physician who is duly licensed to authorize a prescription order or refill in the ordinary course of his or her professional practice.

Covered Services include, but are not limited to the following:

- Prescription Legend Drugs which are dispensed pursuant to a prescription order, under federal law or state law, including Specialty Medications used to treat rare conditions and advanced diseases.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a provider in an office or facility.
- Self-injectable insulin and supplies and equipment used to administer insulin and prescribed oral diabetes medications;
- Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.
- Self-administered contraceptive Drugs and devices, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, diaphragms, cervical caps and contraceptive rings. Benefits are available for the emergency oral contraceptive "morning after pill," for female Members.

  Please see "Preventive Care" in Section 7 of your certificate for more information about contraceptive Prescription Drugs and devices for women. As required by law, Generic and single-source Brand contraceptives for women are Preventive Care Services and are covered in full when furnished by a Network Pharmacy. Multi-source Brand Drugs and devices will be covered as a Preventive Care benefit only if your physician determines that a Multi-source Brand is medically necessary and writes, "Dispense as Written" or "Do not Substitute" on your Prescription. As required by law, over-the-counter contraceptive products for women are Preventive Care Services and are covered in full when purchased at a Network Pharmacy with a Prescription from your physician.
- Vitamin supplements that require a prescription by law;
- Flu Shots (including administration). These will be covered in full under the "Preventive Care" benefit in Section 7 of your certificate when furnished by a Network Provider.
- Immunizations required by the "Preventive Care" benefit in Section 7 of your certificate.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered in full under the "Preventive Care" benefit in Section 7 of your certificate when furnished by a Network Pharmacy.
- FDA-approved smoking cessation products including over-the-counter nicotine replacement products, when obtained with a Prescription. These products will be covered in full under the "Preventive Care" benefit in Section 7 of your certificate when furnished by a Network Pharmacy.
- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Benefits are available for Prescription Drugs prescribed for off-label use if recognized for treatment of the indication in one of the standard reference compendia; or in the medical literature, as recommended by current American Medical Association policies. However, no benefits are available for a Drug prescribed for off-label use if the FDA has determined its use to be contraindicated for the prescribed use.

Benefits include Covered Prescription Drugs that are given to you while you participate in an approved clinical trial. 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. The Experimental / Investigational Drug itself is not covered.

II. Prior Authorization

Network Pharmacies are notified about Drugs that require Prior Authorization at the time you fill your Prescription. The Network Pharmacist may contact the Pharmacy Benefits Manager at 1-800-338-6180.

If your physician has not obtained Prior Authorization and he/she is not available at the time of dispensing, the Network Pharmacist will contact the Pharmacy Benefits Manager.

- If clinical information is <u>not</u> required to fill your Prescription, the authorization will be approved.

- If clinical information is required, your Prescription may not be immediately filled. The Pharmacy Benefits Manager will contact the prescribing physician and will respond to your physician within 48 hours of receiving

  the supporting clinical rationale. A Prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.

Out-of-Network Pharmacies are not notified about Drugs that require Prior Authorization. If the Pharmacy Benefits Manager determines that clinical information is required, your prescribing physician will be required to submit supporting clinical information before your claim can be processed. Anthem will respond to your physician within 48 hours of receipt of the clinical information. A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.

A non-formulary Prescription is a Prescription that is <u>not</u> on Anthem's prescription drug list. Coverage is available for non-formulary Prescriptions only if the prescribed service is a Covered Service as stated in this section, is not subject to an exclusion stated in this Certificate and you obtain Prior Authorization from Anthem**.** Otherwise, no Benefits are available and you are responsible for paying the full cost of the non-formulary Prescription.

Exception Request for a Drug not on the Prescription Drug List

If you or your physician believes you need a Prescription Drug that is not on the prescription drug list, please have your physician or pharmacist get in touch with Anthem. Anthem will cover the other Prescription Drug only if Anthem agrees that it is Medically Necessary and appropriate over the other Drugs that are on the List. In non-exigent circumstances, a Prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours. If Anthem approves the coverage of the Drug, coverage of the Drug will be provided for the duration of your Prescription, including refills. If Anthem denies 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.

You or your physician 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 Plan. Anthem will make a coverage decision within 24 hours of receiving your request. If Anthem approves the coverage of the Drug, coverage of the Drug will be provided for the

duration of the exigency. If Anthem denies 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.

Coverage of a Drug approved as a result of your request or your physician's request for an exception will only be provided if you are a Member enrolled under the Plan.

Non-formulary Prescriptions authorized according to the terms of this subsection will be subject to the Tier 3 cost sharing amount shown on the Cost Sharing Schedule.

The authorization of a Prescription Drug does not modify the prescription drug list. Inclusion of a Drug or related item on the prescription drug list is not a guarantee of coverage. Coverage is subject to all of the terms of this certificate. You have the right to appeal a decision made by Anthem. Please see Section 11 in your certificate for the appeal procedure.

III. About Special Programs

Except when prohibited by federal regulations (such as HSA rules), from time to time Anthem may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, mail order Drugs, over the counter or *preferred* products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or *preferred* products for a limited period of time.

Therapeutic Drug Substitution Program - Your pharmacy Benefits include a therapeutic drug substitution program approved by Anthem and managed by the Pharmacy Benefits Manager. This is a voluntary program designed to inform Members and physicians about possible alternatives to certain prescribed drugs. The Pharmacy Benefits Manager may contact you and your prescribing physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your physician can determine whether the therapeutic substitute is appropriate for you.

Half-Tablet Program - Allows Members to pay a reduced Copayment on selected "once daily dosage" medications. It also allows Members to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the physician to take "½ tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. This program is strictly voluntary and the Member's decision to participate should follow consultation with and the agreement of his/her physician. For more information about this program, call Anthem's call center or visit Anthem's website at www.anthem.com.

IV. Pharmacy Options

Benefits are available for covered prescriptions when purchased at a Network Pharmacy or Network Specialty Pharmacy. Prescriptions must meet all of the criteria stated in this rider and must be covered as described in "Covered Services" (above). Otherwise, no Benefits are available.

Network Pharmacies and Specialty Pharmacies accept Anthem's allowable Benefit as payment in full for Covered Services. For a list of pharmacies in the network please visit Anthem's website www.anthem.com.

You must show your identification card at a Network Pharmacy and Specialty Pharmacy. If you do not show your identification card, you will be required to pay the full cost of the prescription. To obtain reimbursement, a completed claim form must be submitted as directed on the form. Reimbursement is limited to the allowable Benefit, minus your cost sharing (Copayment, Deductible, and/or Coinsurance). The allowable Benefit (contracted discount rate with pharmacy) is the dollar amount available for a specific prescription item.

Please see "Cost Sharing" (below) for more information about your share of the cost.

Important Note: If Anthem determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, Anthem may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single Network Pharmacy. Anthem will contact you if use of a single Network Pharmacy is needed. Anthem will give you options as to which Network Pharmacy you may use. If you do not select one of the Network Pharmacies Anthem offers within 31 days, Anthem will select a single Network Pharmacy for you. You have the right to appeal Anthem's decision. Please see Section 11 of your certificate for the appeal procedure.

V. Cost Sharing

Depending on the plan chosen by your Group, the following types of cost sharing may apply to Covered Services under this rider, as shown on your *Cost Sharing Schedule.* These are separate cost sharing amounts that do not count toward meeting any Deductible or Coinsurance Maximum described in your Subscriber Certificate.

Your Copayment will not be reduced by any discounts, rebates or other funds received by the Pharmacy Benefits Manager from drug manufacturers, wholesalers, distributors, similar vendors or funds received by Anthem from the Pharmacy Benefits Manager.

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

Copayment - a fixed dollar amount you pay *each time* you fill (or refill) a prescription. Your prescription drug Copayment will be the lesser of your scheduled Copayment amount or the retail price charged for your prescription by the pharmacy that fills your prescription.

There are three Copayment tiers. The Copayment amount you pay depends on whether the prescription drug has been classified by Anthem as a Tier 1, Tier 2, or Tier 3, drug. Anthem's determination of a Copayment tier is based on:

- clinical information,
- (if appropriate), the cost effectiveness of the drug relative to other drugs in its therapeutic class or use for the treatment of the same or similar condition; and
- the availability of an over-the-counter alternative.

The classification of pharmaceutical products is developed in consultation with physicians and pharmacists and approved for their quality and cost effectiveness. If you are adversely affected by a change to the prescription drug list, Anthem will notify you at least 45 days before the change is made.

A **Tier 1 Copayment** generally applies to generic prescription drugs.

A **Tier 2 Copayment** generally applies to brand name prescription drugs, but may include more costly or newer generic drugs.

A **Tier 3 Copayment** generally applies to brand name prescription drugs that have been (compounded) by your pharmacist or that based upon their clinical information and cost effectiveness are not preferred relative to other drugs in the other tiers.

Note: to determine the Copayment tier of your prescription, you are encouraged to visit Anthem's website at www.anthem.com. You may also request a copy of the prescription tier drug list by calling Anthem's Customer Service at the number listed on your identification card. Please see your Cost Sharing Schedule for information about your cost sharing amounts.

Copayment amounts apply as follows:

- You pay one Copayment for each prescription filled (or refilled) up to a 30-day supply.

- At a retail pharmacy, any single fill (or refill) exceeding the 30-day limit requires additional Copayments. You pay two Copayments for a supply of 31 to 60 days. You pay three Copayments for supplies of 61 to 90 days. Twelve Copayments are required each time you fill a prescription for a prescription device for 12 months.

- You pay two Copayments for each prescription filled (or refilled) up to a 90-day supply for maintenance medications through a mail order pharmacy. Any single fill (or refill) exceeding the 90-day limit requires additional Copayments. For example, eight Copayments are required each time you fill a prescription for a prescription device for 12 months.

- You pay one Tier 1 Copayment each time you fill a prescription for a diabetic supply.

Certain Preventive Care pharmacy services are covered in full as required by law. Please see the "Covered Services" section above in this rider for complete information.

Important Note: In addition to your cost sharing described above, If you purchase a Brand name prescription when there is a Generic prescription available, you pay the difference between the Maximum Allowed Amount for the Brand prescription and the Maximum Allowed Amount for the Generic prescription. You pay the difference unless your physician indicates on the prescription order that a Generic substitution is not medically appropriate. For example: the Maximum Allowed Amount of a Brand name prescription is $50. A Generic substitution is available. The Maximum Allowed Amount of the Generic prescription is $40. You pay the $10 difference. The $10 difference is not applied towards any other cost sharing requirement. Any applicable Deductible, Coinsurance and/or Copayment are based on the retail price of the Brand prescription.

VI. Limitations

You may purchase up to a 90-day supply of a covered prescription drug at one time, provided that the drug is a Covered Service, the quantity is ordered by your physician and the drug does not require Prior Authorization from Anthem. The following limitations apply to Covered Services under this rider:

- Law regulates supplies of controlled substances. To be eligible for Benefits, they must be purchased at a retail pharmacy. They cannot be purchased from the mail service pharmacy.

- Benefits are available for prescription therapeutic equivalent alternative drugs. Therapeutic equivalent alternative drugs are chemically and therapeutically equivalent to drugs in the same drug category. For the majority of individuals, these drugs can be expected to produce similar clinical outcomes for certain diseases or conditions.

  Certain prescription drugs are not covered when a prescription therapeutic equivalent alternative drug is available unless:

  - Required by law, or
  - The prescription is Medically Necessary, as defined in your Certificate, and
  - Your prescribing physician provides Anthem with a written statement that includes the reasons why the use of that prescription drug is more medically beneficial than the therapeutic equivalent alternative drug.

VII. Exclusions

In addition to the limitations and exclusions stated in Section 8 of your Subscriber Certificate, the following services are not covered.

- Prescriptions taken by or administered to a Member in any Outpatient setting, including contraceptive drugs and devices that must be administered in a physician's office, Prescriptions taken by or administered to a Member who is a patient in a licensed hospital, nursing home, sanitarium or similar institution, or charges for such administration.
- Appetite suppressants, anorectics, or any drug used for the purpose of weight management
- Vaccines, toxoids (substance used to produce immunity such as tetanus toxoids)
- Biologicals, blood or blood plasma, plasma expanders or proteins
- Cosmetic agents or medications used for cosmetic purposes
- Prescriptions that are not approved by the FDA for clinical use
- Except as stated in I, "Covered Services," nonlegend (over-the-counter) prescriptions, including:
    - prescriptions for which there is an over-the-counter (OTC) therapeutic equivalent,
    - vitamins or other dietary substances that do not require a prescription by law,
    - supplies that can be used for non-medical purposes, such as alcohol or alcohol wipes, and
    - homeopathic products or herbal remedies
- Replacement prescriptions resulting from loss, theft, or damage
- Compounded Prescription Legend Drugs unless all of the ingredients are FDA-approved and 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.
- Therapeutic devices or appliances, support garments and non-medical substances regardless of intended use, including non diabetic needles and syringes. Please see your Subscriber Certificate for more information about coverage for some of these items.
- Prescription refills that exceed the physician's order or refills dispensed after one year from the physician's original order
- Any prescription that is not Medically Necessary, as defined in your Subscriber Certificate
- Fertility hormones and fertility drugs
- Hormones and drugs for sex change treatment, therapy, programs or surgery
- Drugs to treat sexual or erectile problems

VIII. Definitions

Brand Drug means a prescription that is marketed under its trade name.

Generic Drug means a prescription that is chemically and therapeutically equivalent to a Brand name product.

Maximum Allowed Amount. For prescription drugs, the Maximum Allowed Amount is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

Network Pharmacy means a pharmacy that has a written agreement with the Pharmacy Benefits Manager to provide Covered Services to Members. Network Pharmacies accept Anthem's Maximum Allowed Amount as payment in full for Covered Services.

Network Specialty Pharmacy means a pharmacy that has a written agreement with the Pharmacy Benefits Manager to provide Covered Services to Members. Covered Services include providing clinical care support, medication management, coordinating the delivery of medication (directly to you or your physician's office), and assisting Members in obtaining Prior Authorization. Network Specialty Pharmacies accept Anthem's Maximum Allowed Amount as payment in full for Covered Services.

Out-of-Network Pharmacy means a pharmacy that does not have a written agreement with the Pharmacy Benefits Manager to provide Covered Services to Members.

Prescription Legend Drug, Prescription Drug, or Drug means a medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Rider. Over the counter drugs that are recommended by the U.S. Preventive Services Task Force (USPSTF) as Preventive Services are considered Prescription Legend Drugs.

Prior Authorization means the process of obtaining authorization for services or certain covered drugs that have been approved by the Food and Drug Administration (FDA) for specific medical conditions by reviewing related documentation, verifying benefits and medical necessity to assure the service is a covered service and is medically necessary. These services are reviewed to make sure the patient is getting the appropriate treatment regimens based on medical guidelines to assure the highest quality outcome for the patient and decreasing costs without compromising the quality of care. The approval criteria was developed and endorsed by the Anthem Pharmacy and Therapeutics Committee and is based on information from the FDA and manufacturers, medical literature, actively practicing consultant physicians and appropriate external organizations.

Specialty Medication means prescriptions that are prescribed for the treatment of rare conditions and advanced diseases. These drugs are sometimes difficult to obtain at a retail pharmacy, are often administered by injection and may require special handling, such as temperature controlled packaging. Specialty Medications must be furnished by a Specialty Pharmacy.

IX. About the Pharmacy Benefits Manager

Anthem contracts with a Pharmacy Benefits Manager to manage the pharmacy Benefits available under this rider. The Pharmacy Benefits Manager has a nationwide network of retail pharmacies, specialty pharmacies and mail order pharmacies.

The Pharmacy Benefits Manager has established a National Pharmacy &Therapeutics Committee which consists of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining whether a drug should be included in Anthem's prescription tier list, 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, and drug profiling initiatives.

Pharmacy services - Pharmacy services include, but are not limited to: providing clinical pharmacy management services, making recommendations to and updating the prescription drug tier list, managing a network of retail pharmacies and operating the mail order pharmacy services. In consultation with Anthem, the Pharmacy Benefits Manager provides services to promote and enforce the appropriate use of pharmacy Benefits, such as review for possible excessive use; recognized and recommended dosage regiments; optimization of medication therapy; drug interactions or drug/pregnancy concerns.

Specialty Pharmacy services - Specialty Pharmacy services include, but are not limited to: providing clinical care support, medication management, coordinating the delivery of medication (directly to you or your physician's office), and assisting Members in obtaining Prior Authorization.

You may review a copy of the most current prescription drug tier list and Specialty Medications on Anthem's website www.anthem.com. You may also request copies of these materials by calling Anthem's Customer Service.

The toll free telephone number is listed on your identification card. Or, you may call Anthem at 1-800-874-7122. The prescription drug tier list and Specialty Medication list is subject to periodic review and amendment. Inclusion of a drug or related item is not a guarantee of coverage.

Anthem Blue Cross and Blue Shield
1155 Elm Street, Suite 200
Manchester, New Hampshire 03101-1505
Anthem's toll-free telephone number is on your Identification Card.

Lisa M. Guertin
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