Individual Contract

Anthem Bronze Pathway X PPO 0% for HSA

ANTHEM HEALTH PLANS OF KENTUCKY, INC.

13550 Triton Park Blvd.
Louisville, KY 40223

RIGHT TO EXAMINE THIS CONTRACT

If this Contract is provided to You as a new Subscriber, You have 10 days to examine this Contract. If You are not satisfied with this Contract for any reason, You may return it to Us or the agent who sold it to You within 10 days after You receive it or have access to it electronically, whichever is earlier. Your Premium will be refunded and this Contract will be void from its start provided no services have been obtained. If services have been obtained, the Premium You have paid will be promptly refunded, reduced by any amounts We have paid in claims for You.

This Contract is offered through a public exchange operated by the state and/or federal government as part of the Patient Protection and Affordable Care Act ("Exchange"); all enrollment changes must be made through the Exchange by You.

This document is a legal Contract between the Contract owner (Subscriber) and Us.

THIS DOCUMENT, TOGETHER WITH YOUR APPLICATION (INCLUDING ANY AFFIDAVITS) AND YOUR I.D. CARD, IS YOUR CONTRACT. READ YOUR CONTRACT CAREFULLY. The Schedule of Cost-Shares and Benefits shows the Cost-Share option You selected. The Schedule of Cost-Shares and Benefits also provides a brief outline of some of the important features of Your Contract. The Schedule of Cost-Shares and Benefits is not the health Contract, and only the actual Contract provisions will control. The Contract itself is a legal contract and sets forth in detail the rights and obligations of both You and the Plan. **IT IS THEREFORE IMPORTANT THAT YOU READ YOUR CONTRACT.**

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Welcome to Anthem!

We are pleased that You have become a Member of Our health Plan, where it's Our mission to improve the health of the people We serve. We've designed this Contract to give a clear description of Your benefits, as well as Our rules and procedures.

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

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

Many words used in the Contract have special meanings (e.g., Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Contract, You will also see references to "We," "Us," "Our," "You," and "Your." The words "We," "Us," and "Our" mean Anthem Blue Cross and Blue Shield. The words "You" and "Your" mean the Member, Subscriber and each covered Dependent.

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

Anthem Blue Cross and Blue Shield

Deborah Moessner

President

How to obtain Language Assistance

Anthem is committed to communicating with Our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Member Services call centers. Simply call the Member Services phone number on the back of Your Identification Card and a representative will be able to help You. Translation of written materials about Your benefits can also be asked for by contacting Member Services. Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also available by dialing 711. A special operator will get in touch with Us to help with Your needs.

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

(If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling the Member Services number.)

Identity Protection Services

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

Contact Us

Member Services is available to explain policies and procedures, and answer questions regarding the availability of benefits.

For information and assistance, a Member may call or write Anthem.

The telephone number for Member Services is printed on the Member's Identification Card. The address is:

ANTHEM HEALTH PLANS OF KENTUCKY, INC.
13550 Triton Park Blvd.
Louisville, KY 40223

Visit Us on-line
www.anthem.com

Hours of operation
Monday - Friday
8:00 a.m. to 5:00 p.m.

Conformity with Law

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

Acknowledgement of Understanding

Subscriber hereby expressly acknowledges their understanding that this Contract constitutes a contract solely between Subscriber and Anthem Health Plans of Kentucky, Inc. dba Anthem Blue Cross and Blue Shield (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 "Association") permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in the Commonwealth of Kentucky and that Anthem is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem, and that no person, entity, or organization other than Anthem shall be held accountable or liable to Subscriber for any of Anthem's obligations to Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Delivery of Documents

We will provide an Identification Card and Contract for each Subscriber.

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SCHEDULE OF COST SHARES AND BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "What is Covered" section. A list of services that are not covered can be found in the "What is Not Covered (Exclusions)" section.

What will I pay?

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Contract will allow for a Covered Service.

The Deductible applies to all Covered Services with a Copayment and/or Coinsurance, including 0% Coinsurance, except for:

- Network Preventive Care Services required by law
- Pediatric Vision Services
- Services, listed in the chart below, that specifically indicate that the Deductible does not apply

For a detailed explanation of how Your Deductibles and Out-of-Pocket Annual Maximums are calculated, see the "Claims Payments" section. When You receive Covered Services from a Non-Network Provider, You may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

Plan Features

Deductible	**Network Member Pays**	**Non-Network Member Pays**
Individual	$6,400	$19,200
Family	$12,800	$38,400
The individual Deductible applies to each covered family member. No one person can contribute more than their individual Deductible amount. Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that calendar year.		

Coinsurance	**Network Member Pays**	**Non-Network Member Pays**
Coinsurance Percentage (unless otherwise specified under Medical Services below)	0% Coinsurance	30% Coinsurance

Out-of-Pocket Limit (The maximum amount You will pay per calendar year.)	**Network Member Pays**	**Non-Network Member Pays**
Individual	$6,400	$25,600

Out-of-Pocket Limit (The maximum amount You will pay per calendar year.)	**Network** **Member Pays**	**Non-Network** **Member Pays**
Family Includes Deductible, Copayments and Coinsurance	$12,800	$51,200
The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that calendar year. No one person can contribute more than their individual Out-of-Pocket Limit.		

IMPORTANT: You are responsible for confirming that the Provider You are seeing or have been referred to see is a Network Provider for this Plan. It is important to understand that Anthem has many contracting Providers who may not be part of the network of Providers that applies to this Plan.

Anthem can help You find a Network Provider specific to Your Plan by calling the number on the back of Your Identification Card.

Medical Services

Medical Services	**Network** **Member Pays**	**Non-Network** **Member Pays**
Allergy Injections	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Ambulance Service		
Emergency	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance
Non-Emergency Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if a Non-Network Provider is used.	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Autism Spectrum Disorders	Copayment/Coinsurance determined by service rendered.	
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia)	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

Medical Services	Network Member Pays	Non-Network Member Pays
Diagnostic Services		
Outpatient Diagnostic Laboratory and Pathology Services	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Diagnostic Imaging Services and Electronic Diagnostic Tests	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Advanced Imaging Services	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Doctor visits (includes Mental Health and Substance Abuse Office Visit Services)		
Primary Care Physician (PCP) Office Visits. Retail Health Clinic, includes all Covered Services received at a Retail Health Clinic	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Specialty Care Physician (SCP) Office Visits	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Other Office Services	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Durable Medical Equipment (medical supplies and equipment)	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Emergency room visits (Copayment waived if admitted)	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance
Hearing Aids Limited to a maximum of one per affected ear every 36 months	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Home Health Care Limited to a maximum of 100 visits per Member, per Calendar Year. **Private Duty Nursing** (in the home setting) Limited to a maximum of 2,000 hours per calendar year.	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Hospice Care Payment will be no less than Medicare for this benefit	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance
Hospital Services **(includes Mental Health and Substance Abuse Services)**		
Inpatient Facility	$0 Copayment per admission 0% Coinsurance	$0 Copayment per admission 30% Coinsurance
Outpatient Facility	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Inpatient and Outpatient Professional Services	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of 60 days per Member, per Calendar Year. Refer to Hospital Services for Inpatient Facility Cost Shares	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Outpatient Therapy Services: Outpatient Habilitative and Rehabilitative Therapy Services (limits on Physical, Occupational and Speech Therapy services listed below are not combined but separate based on determination of Habilitative service or Rehabilitative service)		
Physical and Occupational Therapy Physical Therapy is limited to a maximum of 25 visits per Member, per Calendar Year Occupational Therapy is limited to a maximum of 25 visits per Member, per Calendar Year **You will not have to pay a Copayment or Coinsurance for Covered Services rendered for each date of service, from an Occupational Therapist or Physical**	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Therapist that is greater than the Copayment or Coinsurance you would pay for Covered Services from a Primary Care Physician for an office visit.		
Speech and Manipulation Therapy Speech Therapy is limited to a maximum of 25 visits per Member, per Calendar Year. Manipulation Therapy is limited to a maximum of 20 visits per Member, per Calendar Year. Refer to "Doctor visits" for Copayment or Coinsurance that applies when an office visit is charged. You will not have to pay a Copayment or Coinsurance for Covered Services rendered for each date of service, for Manipulative Treatment that is greater than the Copayment or Coinsurance you would pay for Covered Services from a Primary Care Physician.	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Chemotherapy, Radiation and Respiratory Therapy **Cardiac Rehabilitation** is limited to a maximum of 36 visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** is limited to a maximum of 25 visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here. **Post-Cochlear Implant Aural Therapy** is limited to 30 visits, per Member, per Calendar Year. **Cognitive Rehabilitation Therapy** is limited to 20 visits, per Member, per Calendar Year.	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Preventive Care Services Network services required by law are not subject to Deductible.	Deductible does not apply $0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Prosthetics Prosthetic devices, their repair, fitting, replacement and components **Prosthetic appliance limits:** Surgical bras – limited to 4 per Member, per Calendar Year. Wigs – limited to the first one following cancer treatment, not to exceed 1 per Member, per Calendar Year.	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Skilled Nursing Care Limited to a maximum of 90 days per Member, per Calendar Year	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Surgery **Ambulatory Surgical Center**	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Temporomandibular and Craniomandibular Joint Treatment	Copayment/Coinsurance determined by service rendered.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $10,000 maximum benefit limit per transplant Unrelated Donor Search - $30,000 maximum benefit limit per transplant	Copayment/Coinsurance determined by service rendered.	
Urgent Care Center	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance

Prescription Drugs

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 Network Pharmacy. If You get Covered Services from any other Network Pharmacy, benefits will be covered at Level 2 and You may pay more in Deductible, Copayments, and Coinsurance.

Level 1 Network Pharmacies. When You go to Level 1 Network Pharmacies, (also referred to as Core Pharmacies), You pay a lower Copayment / Coinsurance on Covered Services than when You go to other Network Providers.

Level 2 Network Pharmacies. When You go to Level 2 Network Pharmacies, (also referred to as Wrap Pharmacies), You pay a higher Copayment / Coinsurance on Covered Services than when You go to a Level 1 Network Pharmacy.

Retail Pharmacy Prescription Drugs	Network Member Pays		Non-Network Member Pays
	Level 1 Pharmacy	Level 2 Pharmacy	
Tier 1	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Tier 3	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance
Tier 4	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance	$0 Copayment 30% Coinsurance

Notes:

Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).

Retail Pharmacy is limited to a 30-day supply per prescription.

Certain Specialty Drugs are only available from Anthem's Specialty Preferred Provider and You will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When You get Specialty Drugs from Anthem's Specialty Preferred Provider, You will have to pay the same Copayments / Coinsurance You pay for a 30-day supply at a Retail Pharmacy.

Mail Order Prescription Drugs	Network Member Pays	Non-Network Member Pays
Tier 1 (90-day supply)	$0 Copayment 0% Coinsurance	Not Covered

Mail Order Prescription Drugs	Network Member Pays	Non-Network Member Pays
Tier 2 (90-day supply)	$0 Copayment 0% Coinsurance	Not Covered
Tier 3 (90-day supply)	$0 Copayment 0% Coinsurance	Not Covered
Tier 4 (30-day supply)	$0 Copayment 0% Coinsurance	Not Covered
Note: Certain Specialty Drugs are only available from Anthem's Specialty Preferred Provider and You will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When You get Specialty Drugs from Anthem's Specialty Preferred Provider, You will have to pay the same Copayments / Coinsurance You pay for a 30-day supply at a Retail Pharmacy. Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).		
Orally Administered Cancer Chemotherapy	You will not have to pay a Cost-Share (e.g., Copayment, Deductible, or Coinsurance) for the Drugs you get at a Retail or Home Delivery (Mail Order) Pharmacy that is higher than the Cost-Share you pay for chemotherapy covered under the "Prescription Drugs Administered by a Medical Provider" benefit.	

Pediatric Dental Services

The following pediatric dental services are covered for Members until the end of the month in which they turn 21.

Covered Dental Services, unless otherwise stated below, are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost Shares and Benefits.

Please see “Pediatric Dental Care” in the “What is Covered” section for more information on pediatric dental services.

Pediatric Dental Care	Network Member Pays	Non-Network Member Pays
Diagnostic and Preventive Services	Deductible does not apply; 0% Coinsurance	Deductible does not apply; 30% Coinsurance
Basic Restorative Services	0% Coinsurance	50% Coinsurance
Oral Surgery Services	0% Coinsurance	50% Coinsurance
Endodontic Services	0% Coinsurance	50% Coinsurance
Periodontal Services	0% Coinsurance	50% Coinsurance
Major Restorative Services	0% Coinsurance	50% Coinsurance
Prosthodontic Services	0% Coinsurance	50% Coinsurance
Dentally Necessary Orthodontic Care Services	0% Coinsurance	50% Coinsurance

Pediatric Vision Services

The following vision care services are covered for Members until the end of the month in which they turn 21. To get the Network benefit You must use a Blue View Vision provider. Visit Our website or call Us at the number on Your ID card if You need help finding a Blue View Vision provider.

Please see “Pediatric Vision Care” in the “What is Covered” section for a more information on pediatric vision services.

Covered vision services are **not** subject to the calendar year Deductible.

Covered Vision Services	Network Member Pays	Non-Network Reimbursement
Routine Eye Exam Covered once per Calendar Year per Member	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Standard Plastic Lenses One set of lenses covered per Calendar Year per Member. One set of replacement lenses is also covered if Medically Necessary.		
Single Vision	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Bifocal	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Trifocal	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Progressive	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Lenticular	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Additional Lens Options Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from Network providers.		
Frames (formulary) One frame covered per Calendar Year per Member. One replacement frame is also covered if Medically Necessary.	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Contact Lenses (formulary) Elective or non-elective contact lenses are covered once per Calendar Year per Member.		
Elective (conventional and disposable) – 12 month supply	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount

Covered Vision Services	Network Member Pays	Non-Network Reimbursement
Non-Elective – 12 month supply	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Standard Contact Lens Fitting and Evaluation Covered once per Calendar Year	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Important Note: Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.		

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

HOW YOUR COVERAGE WORKS

Network Providers are the key to providing and coordinating Your health care services. Benefits are provided when You obtain Covered Services from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services You obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets Our enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the product associated with this Contract.

Network Services and Benefits

If Your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. We have complete authority to determine the Medical Necessity of the service.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other facility. This decision is made upon review of Your condition and treatment. You may appeal this decision. See the “If You Have a Complaint or an Appeal” section of this Contract.

- **Network Providers** - include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for You. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange Your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:

  - You will not be required to file any claims for services You obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Copayments/Coinsurance and/or Deductibles. You may be billed by Your Network Provider(s) for any non-Covered Services You receive or where You have not acted in accordance with this Contract.
  - When required, prior approval of benefits is the responsibility of the Network Provider. See the “Requesting Approval for Benefits” section.

If there is no Network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment, and We may approve a Non-Network Provider for that service as an Authorized Service.

Dental Providers

You do not have to select a particular dentist to receive dental benefits. You can choose any dentist You want for Your dental care. However, Your dentist choice can make a difference in how benefits are covered and how much You will pay out of pocket. You may have more out-of-pocket costs if You use a dentist that is a non-participating dentist. There may be differences in the amount We pay between a participating dentist and a non-participating dentist.

Please call Our Member Service department at (800) 627-0004 for help in finding a participating dentist or visit Our website at www.anthem.com/mydentalvision. Please refer to Your ID card for the name of the dental program that participating providers have agreed to service when You are choosing a participating dentist.

First - Make an Office Visit with Your PCP

Your PCP's job is to help You stay healthy, not just treat You when You are sick. After You pick a PCP, set up an office visit. During this visit, get to know Your PCP and help Your PCP get to know You. You should talk to Your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns You have.

If You do not get to know Your PCP, they may not be able to properly manage Your care. To see a Doctor, call their office:

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

When You go to the office, be sure to bring Your Member Identification Card with You.

If You need to see a Specialist, You can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If You have any questions about Covered Services, call Us at the telephone number listed on the back of Your Identification Card.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider; see Your Schedule of Cost-Shares and Benefits.

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

- The difference between the actual charge and the Maximum Allowed Amount plus any Deductible and/or Copayments/Coinsurance;
- Services that are not Medically Necessary;
- Non-Covered Services;
- Filing claims;
- Higher Cost-Sharing amounts.

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

Continuity of Care

If Your Network Provider leaves Our Network (for other than quality), You may be able to continue seeing that Provider for a limited time (completion of treatment or 90 days, whichever is shorter) and still receive Network benefits. This could happen if You have a disability, a congenital condition, or You are in an active course of treatment. For purposes of this section, an active course of treatment is an ongoing

course of treatment for a life threatening condition, a serious acute condition (examples include chemotherapy, radiation therapy and post-operative visits), a pregnancy in the second or third trimester and through the postpartum period, and a health condition for which a Physician attests that discontinuing care by the current Physician would worsen the condition or interfere with anticipated outcomes. If You wish to continue seeing the same Provider, You or Your Doctor should contact Member Services for details. Any decision by Us regarding a request for Continuity of Care is subject to the Appeals process.

How to Find a Provider in the Network

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

- See Your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's Network.
- Call Member Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with Your Doctor or Provider.

If You need details about a Provider's license or training, or need help choosing a Doctor who is right for You, call the Member Service number on the back of Your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with Your needs.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care You receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies.

Identification Card

When You receive care, You must show Your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Contract. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide a service that was asked for is not Medically Necessary if You have not tried other treatments that are more cost effective.

If You have any questions about the information in this section, You may call the Member Service phone number on the back of Your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. For benefits to be covered, on the date You get service:

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

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
    - **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain Services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.

      For admissions following Emergency Care, You, Your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
    - **Predetermination** – An optional, voluntary Pre-Service Review request for a benefit coverage determination for a service or treatment if there is a related clinical coverage guideline. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.
- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. Post-service reviews are performed when a service, treatment or admission did not need Precertification or did not have a Predetermination review performed. Post-service reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Who is Responsible for Precertification

Typically, Network Providers know which services need Precertification and will get any Precertification when needed or ask for a Predetermination, even though it is not required. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with Us to ask for a Precertification or Predetermination review. However, You may request a Precertification or Predetermination, or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to get Precertification	Comments
Network	Provider	• The Provider must get Precertification when required.
Non-Network/Non-Participating	Member	• Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
BlueCard® Provider	Member **(Except for Inpatient Admissions)**	• Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **BlueCard Provider must obtain precertification for all Inpatient Admissions.**
NOTE: For Emergency admissions, You, Your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

We will use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical

Provider." Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

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

If You are not satisfied with Our decision under this section of Your benefits, please refer to the "If You Have a Complaint or an Appeal" section of Your benefits to see what rights may be available to You.

Decision and Notice Requirements

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

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

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

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

Important Information

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

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

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

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line pre-certification list, or contacting the Member Services number on the back of Your ID Card.

Health Plan Individual Case Management

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

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

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

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

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

WHAT IS COVERED

This section describes the Covered Services available under this Contract. Covered Services are subject to all the terms and conditions listed in this Contract, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements.

Please read the following sections of this Contract for more information about the Covered Services described in this section:

- Schedule of Cost-Shares and Benefits – for amounts You need to pay and benefit limits
- Requesting Approval for Benefits – for details on selecting providers and services that require pre-authorization
- What is Not Covered (Exclusions) – for details on services that are not covered

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

You should also know that many Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where You choose to get Covered Services, and this can result in a change in the amount You need to pay.

Medical Services

Ambulance Services (Air, Ground and Water)

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

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

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

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

Non-Network Providers may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by the Plan.

All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to Medical Necessity review by the Plan. The Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all types of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorder Services

The diagnosis and treatment of Autism Spectrum Disorders is covered. Autism Spectrum Disorders means a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") published by the American Psychiatric Association, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Treatment for Autism Spectrum Disorders includes the following care for an individual diagnosed with any of the Autism Spectrum Disorders:

- Medical care - services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;
- Habilitative or rehabilitative care - professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;
- Pharmacy care - Medically Necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority and any medically necessary health-related services to determine the need or effectiveness of the medications;
- Psychiatric care - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;
- Psychological care - direct or consultative services provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;
- Therapeutic care - services provided by licensed speech therapists, occupational therapists, or physical therapists; and
- Applied behavior analysis prescribed or ordered by a licensed health or allied health professional. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

No reimbursement is required under this section for services, supplies, or equipment:

- For which the Member has no legal obligation to pay in the absence of this or like coverage;
- Provided to the Member by a publicly funded program;

- Performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made;
- For services provided by persons who are not licensed as required by law;
- For treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
- For treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental/Investigational;
- For tuition or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;
- For learning, motor skills and primary communication disorders, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder;
- For treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias;
- For intensive behavioral therapies such as Applied Behavioral Analysis for Autism Spectrum Disorder for Covered Persons age 22 years or older;
- For the diagnosis or treatment of mental illness that, in Anthem's reasonable judgment, are any of the following:
  a) Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
  b) Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered Experimental/Investigational.
  c) Not consistent with the Anthem's level of care guidelines or best practices, as modified from time to time.
  d) Not clinically appropriate for the Member's condition based on generally accepted standards of medical practice and benchmarks.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. The peer review requirement shall not be applicable to cancer Clinical Trials provided by i-iii below.
      i. The Department of Veterans Affairs.

ii. The Department of Defense.
iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize Your benefits.

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

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

Dental Services

Accident Related Dental Services

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

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

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Benefits are provided for anesthesia and Hospital or facility charges for services performed in a Hospital and Ambulatory Surgical Facility in connection with dental procedures for Dependents below the age of nine years, Members with serious mental or physical conditions, and Members with significant behavioral problems, where the admitting Physician or treating dentist certifies that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness.

Benefits are not provided for routine dental care.

If the above paragraph is not applicable to a Member, the only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Diabetes Services

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self-Management Training is covered for an individual with insulin dependent diabetes, noninsulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

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

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances”. Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services Outpatient

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist.

Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Doctor (Physician) Visits

Covered Services include:

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

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

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care Services" benefit described later in this section.

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

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

Allergy Services for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

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

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

Emergency Care Services

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

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition", means a medical condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's health in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions.

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

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

If You are admitted to the Hospital from the Emergency Room, be sure that You or Your Doctor calls Us as soon as possible. We will review Your care to decide if a Hospital stay is needed and how many days You should stay. If You or Your Doctor do not call Us, You may have to pay for services that are determined to be not Medically Necessary.

Stabilize, with respect to an Emergency Medical Condition, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Treatment You get after Your condition has stabilized is not Emergency Care. If You continue to get care from a Non-Network Provider, Covered Services will be covered at the Non-Network level unless We agree to cover them as an Authorized Service.

Habilitative Services

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

Home Care Services

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

Covered Services include but are not limited to:

- Visits by a licensed health care professional, including nursing services by an R.N. or L.P.N, a therapist, or home health aide.
- Infusion Therapy; refer to “Other Therapy Services”, later in this section for more information.
- Medical / social services.
- Diagnostic services.
- Nutritional guidance.
- Training of the patient and/or family/caregiver.
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Medical supplies.
- Durable medical equipment.
- Therapy Services. (except for Manipulation Therapy, which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Private Duty Nursing.

Hospice Care

Hospice care is a coordinated plan of home, inpatient and/or outpatient care that provides palliative, supportive medical, psychological, psychosocial, and other health services to terminally ill patients.

Covered Services and supplies are those listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services and home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) Your physician and the Hospice medical director must certify that You are terminally ill and generally have less than 6 months to live, and (2) Your physician must consent to Your care by the Hospice and must be consulted in the development of Your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to Us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Hospital Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting. Benefits for room, board, nursing and ancillary services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.
- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Treatment for a health problem by a Doctor who is not Your surgeon while You are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate Doctors.

- A personal bedside exam by another Doctor when asked for by Your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.
- Newborn Diet. Covered Services include a 100% human diet to supplement the mother's breast milk or donor milk with a milk fortifier if the diet is:

  1. Prescribed for the prevention of Necrotizing Enterocolitis and associated comorbidities; and
  2. Administered under the direction of a Physician.

  "100% human diet" means supplementing the mother's expressed breast milk or donor milk with a milk fortifier. "Milk fortifier" means a commercially prepared human milk fortifier made from concentrated 100% human milk.

Outpatient Hospital Care

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Center,
- Mental Health and Substance Abuse Facility,
- Other Facilities approved by Us.

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

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

Inborn Errors of Metabolism or Genetic Conditions

Benefits include coverage for the necessary care and treatment of medically diagnosed inborn errors of metabolism or genetic conditions.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Maternity services incurred prior to Your Effective Date are not covered.

Covered maternity services include:

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

Note: Under federal law, We may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider,

after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, We may not require a Provider to get authorization from Us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Post-delivery Care Home Visit

Covered Services include (1) one at-home post-delivery care visit is provided to You at Your residence by a Physician or Nurse when performed no later than 72 hours following You and Your newborn child's discharge from the Hospital. Coverage for this visit includes:

- Parent education
- Physical assessments
- Assessment of the home support system
- Assistance and training in breast or bottle feeding
- Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child. This includes the collection of an adequate sample for the hereditary and metabolic newborn screening.

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

Contraceptive Benefits

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

Sterilization Services

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

Abortion Services

Coverage includes benefits for abortion to preserve the life of the female upon whom the abortion is performed.

Endometriosis and Endometritis

Your Plan also covers the diagnosis and treatment of endometriosis and endometritis.

Medical Supplies, Durable Medical Equipment and Appliances

Durable Medical Equipment and Medical Devices

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

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

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by Us. We may limit the

amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs, except when damage is due to neglect. Benefits also include supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Hearing Supplies

Benefits are available for Members who are certified as deaf or hearing impaired by either a physician or licensed audiologist. Covered Services include:

- Hearing Aids – Any wearable, non disposable instrument or device designed to aid or compensate for impaired human hearing.
- Cochlear implants – A surgically implanted device that allows hearing.

Orthotic Devices

Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

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

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

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

Benefits for repairs and replacement do not include the following:

1) Repair and replacement due to misuse, malicious breakage or gross neglect.
2) Replacement of lost or stolen items.

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

Non-covered items include but are not limited to:

1) Orthopedic shoes;
2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
4) Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Member Service number on the back of your Identification Card.

Prosthetics

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

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

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

Medical and Surgical Supplies

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

Diabetic Equipment and Supplies

Your Plan includes coverage for diabetic equipment and supplies (insulin pump, blood glucose monitor, lancets and test strips, etc.)

Blood and Blood Products

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

Mental Health and Substance Abuse Services

Benefits are available for the diagnosis, crisis intervention and treatment of acute Mental Disorders and Substance Abuse Conditions. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition. For the purposes of this section the Joint Commission is abbreviated as JCAHO and the Commission on Accreditation of Rehabilitation Facilities is abbreviated as CARF.

Covered Services include the following:

- Inpatient Services in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- Outpatient Services including in-home and office visits and treatment in an outpatient department of a Hospital or JCAHO or CARF-accredited outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- Online Visits when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.
- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center accredited by JCAHO or CARF. It offers individualized and intensive treatment and includes:
    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

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

Preventive Care Services

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

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
    - Breast cancer,
    - Cervical cancer,
    - High blood pressure,
    - Type 2 Diabetes Mellitus,
    - Cholesterol,
    - Child or adult obesity.
    - Colorectal cancer, including complete colorectal cancer screening, exams and related lab tests as specified in the most recent version of the American Cancer Society guidelines;
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - Contraceptive coverage includes Generic Drugs and single-source Brand Name Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Name Drugs will be covered, as preventive care benefits when Medically Necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail order) Pharmacy".
    - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per calendar year or as required by law.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
    - Counseling
    - Prescription Drugs
    - Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

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

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
   - Aspirin
   - Folic acid supplement
   - Vitamin D supplement
   - Bowel preparations

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

You may call Member Service at the number on Your Identification Card for more details about these services or view the federal government's web sites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

Rehabilitative Services

Health care services that help You keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Skilled Nursing Facility

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

Surgery

Your Plan covers surgical services on an Inpatient or Outpatient basis, including surgeries performed in a doctor's office or an ambulatory surgical center. Covered Services include:

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

Reconstructive Surgery

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

Note: This section does not apply to orthognathic surgery.

Mastectomy Notice

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

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services Outpatient

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services at spas or health clubs.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Manipulation therapy** – Includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility or doctor's office. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to You through an I.V. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Also covers prescription drugs when they are administered to You as part of a doctor's visit, home care visit, or at an outpatient Facility.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore Your health after an illness or injury.

- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Physical Medicine and Rehabilitation Services

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

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

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

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

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us, including necessary acquisition procedures, mobilization, collection and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

Unrelated Donor Searches

When approved by the Plan, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider Agreement. Contact the Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility. Services received from a Non-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize Your benefits, You will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Please call Us to find out which Hospitals are Network Transplant Providers. Contact the Member Service telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the mobilization, collection and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Doctor (Physician) Visits and Office Services depending where the service is performed subject to Member cost shares.

Urgent Care Services

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

Benefits for urgent care may include:

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

Prescription Drugs

Prescription Drugs Administered by a Medical Provider

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

Important Details About Prescription Drug Coverage

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

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

- quantity, dose, and frequency of administration;
- specific clinical criteria (including requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- specific provider qualifications (including REMS certification (Risk, Evaluation and Mitigation Strategies));
- step therapy requiring one drug or a drug regimen or another treatment be used prior to use of another drug or drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another;
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness).

Precertification

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

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

Please refer to the section "Requesting Approval for Benefits" for more details.

If precertification is denied You have the right to file a Grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Contract.

Designated Pharmacy Provider

Anthem, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with Us. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient Care Coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

We may also require You to use a Designated Pharmacy Provider to obtain Specialty Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve Our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in Our discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Non-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com.

Therapeutic Substitution

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

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

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

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

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if Your Drugs should be covered. Your Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for Us to decide benefits.

Prior Authorization

Prescribing Providers must obtain prior authorization for drug edits in order for You to get benefits for certain Drugs. At times, Your Provider will initiate a Prior Authorization on Your behalf before Your Pharmacy fills Your prescription. At other times, the Pharmacy may make You or Your Provider aware that a Prior Authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

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

- quantity, dose, and frequency of administration;
- specific clinical criteria (including requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- specific provider qualifications (including REMS certification (Risk, Evaluation and Mitigation Strategies));

- step therapy requiring one drug or a drug regimen or another treatment be used prior to use of another drug or drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another;
- use of a Prescription Drug List (as described below).

You or Your provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or alternate benefits, if in Our sole discretion; such change furthers the provision of cost effective, value based and/or quality services.

If Prior Authorization is denied You have the right to file a Grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Contract.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration).
- Therapeutic food, formulas, supplements, and low protein modified food products prescribed for the treatment of inborn errors of metabolism or genetic conditions, if the food is obtained under the direction of a Physician. Prior Authorization is required.
- Self-administered anti-cancer Drugs.

Where You Can Get Prescription Drugs

Network Pharmacy

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

Note: If We determine 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, We 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. We will contact You if We determine that use of a single Network Pharmacy is needed and give You options as to which Network

Pharmacy You may use. If You do not select one of the Network Pharmacies We offer within 31 days, We will select a single Network Pharmacy for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "If You have a Complaint or an Appeal" section of this Contract.

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 Network Pharmacy. If You get Covered Services from any other Network Pharmacy, benefits will be covered at Level 2 and You may pay more in Deductible, Copayments, and Coinsurance.

Level 1 Network Pharmacies. When You go to Level 1 Network Pharmacies, (also referred to as Core Pharmacies), You pay a lower Copayment / Coinsurance on Covered Services than when You go to other Network Providers.

Level 2 Network Pharmacies. When You go to Level 2 Network Pharmacies, (also referred to as Wrap Pharmacies), You pay a higher Copayment / Coinsurance on Covered Services than when You go to a Level 1 Network Pharmacy.

Specialty Pharmacy

We have a list of certain Specialty Drugs that We may require You or Your Doctor to order from the PBM's Specialty Pharmacy. This list may change from time to time. Specialty Drugs that You must receive from the Specialty Pharmacy are limited distribution drugs as well as those Drugs that require special handling, provider coordination, or patient education that cannot be provided by a Retail Pharmacy. If You or Your provider believes that Your Retail Pharmacy can provide the special handling, provider coordination, and/or patient education, You may contact Us at the Member Services number on the back of Your Identification Card to request an exception to receive the Specialty Drug at the Retail Pharmacy.

When You use the PBM's Specialty Pharmacy its patient care coordinator will work with You and Your Doctor to get prior authorization and to ship Your Specialty Drugs to Your home or Your preferred address. Your patient care coordinator will also tell You when it is time to refill Your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have Your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver Your specialty Drugs to You by mail or common carrier for self administration in Your home. You cannot pick up Your medication at Anthem.

Specialty Pharmacy Program

If You are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow You to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If You order Your specialty drug through the Specialty Preferred Provider and it does not arrive, if Your physician decides that it is Medically Necessary for You to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow You to get an emergency supply of medication from a Participating Pharmacy near You. A Member Service representative from the Specialty Preferred Provider will coordinate the exception and You will not be required to pay additional Coinsurance.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets You get certain Drugs by mail if You take them on a regular basis (Maintenance Medication). You will need to contact the PBM to sign up when You first use the service. You can mail written prescriptions from Your Doctor or have Your Doctor send the

prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when You ask for a prescription or refill.

Maintenance Medication

A Maintenance Medication is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure the Prescription Drug You are taking is a Maintenance Medication, please call Member Service at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

If You are taking a Maintenance Medication, You may get the first 30 day supply and one 30 day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication You get without registering Your choice each year through the Home Delivery Pharmacy. You can tell Us Your choice by phone at 888-772-5188 or by visiting Our website at www.anthem.com.

When using Home Delivery, We suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the mail order program, You can call Member Service toll-free at 1-800-281-5524.

The Prescription must state the dosage and Your name and address; it must be signed by Your Physician.

The first mail order Prescription You submit must include a completed patient profile form. This form will be sent to You upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables, except Insulin. Please check with the mail order Prescription Drug program Member Services department at 1-866-274-6825 for availability of the Drug or medication.

Non-Network Pharmacy

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

- Name and address of the Non-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

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

What You Pay for Prescription Drugs

Tiers

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

To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 Network Pharmacy.

- **Tier 1** Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- **Tier 2** Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 3** Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 4** Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

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

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy benefits manager from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy benefits manager.

Prescription Drug List

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

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

If You have a question regarding whether a Drug is on the Prescription Drug Formulary, please refer to Our website at www.anthem.com.

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

Your Benefit Program limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of prescription drugs, and may be different than the formulary for other Anthem products. Benefits may not be covered for certain drugs if they are not on the prescription drug list. Generally, it includes select generic drugs with limited brand prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this formulary from time to time. A description of the prescription drugs that are listed on this formulary is available upon request and at www.anthem.com.

Exception Request for a Drug not on the Prescription Drug List

If You or Your Doctor believe You need a Prescription Drug that is not on the Prescription Drug List, please have Your Doctor or pharmacist get in touch with Us. We will cover the other Prescription Drug only if We agree that it is Medically Necessary and appropriate over the other Drugs that are on the List. We will make a coverage decision within 72 hours of receiving Your request. If We approve the coverage of the Drug, coverage of the Drug will be provided for the duration of Your prescription, including refills. If

We deny coverage of the Drug, You have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving Your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of Your prescription, including refills.

You or Your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function, or if You are undergoing a current course of treatment using a drug not covered by the Plan. We will make a coverage decision within 24 hours of receiving Your request. If We approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If We deny coverage of the Drug, You have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 hours of receiving Your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

Coverage of a Drug approved as a result of Your request or Your Doctor's request for an exception will only be provided if You are a Member enrolled under the Plan.

Drug Utilization Review

If the utilization guidelines of a Prescription Drug(s) suggest there are patterns of its over-utilization or misuse, Your selection of Network Pharmacies may be limited. If this happens, We 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 Network Pharmacy. We will contact You if We determine that use of a single Network Pharmacy is needed and give You options as to which Network Pharmacy You may use. If You do not select one of the Network Pharmacies We offer within 31 days, We will select a single Network Pharmacy for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "If You Have a Complaint or an Appeal" section of this Contract.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

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

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

As required by Kentucky law, this Plan will cover refills of prescription eye drops as follows:

- For a 30-day supply, between 25 and 30 days from the later of a) the original date the prescription was filled, or b) the date you received your most recent refill.
- For a 90-day supply, between 80 and 90 days from the later of a) the original date the prescription was filled, or b) the date you received your most recent refill.
- The Plan will also cover one additional bottle of drops every 3 months when the additional bottle is requested by you or your prescribing Provider at the time the original prescription is filled, and the Provider indicates on the prescription that the additional bottle is needed by you for use in a day care center or school.

Half-Tablet Program

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

Therapeutic Substitution

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

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted prescription drugs if Your Prescription Drugs or dose changes between fills, by allowing only a portion of Your prescription to be filled at a Specialty pharmacy. This program also saves You out of pocket expenses.

The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these prescription drugs by calling the toll-free Member Services number on Your Member ID card or log on to the Member website at www.anthem.com.

Special Programs

Except where prohibited by Federal Regulations (such as HSA rules), from time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our formulary.

Pediatric Dental Care

Your Dental Benefits. Dental care treatment decisions are made by You and Your dentist. We cover treatment based on what benefits You have, not whether the care is Medically or dentally Necessary. Orthodontic care is an exception. We do review those services to make sure they're appropriate. Also, services for tooth reimplantation will be covered if Medically Necessary.

Pretreatment Estimates. When You need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it's best to go over a care or treatment plan with Your dentist beforehand. It should include a "pretreatment estimate" so You know what it will cost.

You or Your dentist can send Us the pretreatment estimate to get an idea of how much of the cost Your benefits will cover. Then You can work with Your dentist to make financial arrangements, before You start treatment.

Pediatric Dental Essential Health Benefits. The following dental care services are covered for Members until the end of the month in which they turn 21. All Covered Services are subject to the terms, limitations, and exclusions of this Contract. See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

Oral Exams. Covered two times per 12 months. The following types of oral exams are covered:

- Periodic – a routine dental exam to check in on Your dental health
- Oral exam for children under 3 years of age

Radiographs (x-rays)

- Bitewings – 2 sets per 12 month period.
- Periapicals (Intra/Extraoral) – 2 per 12 month period.
- Full mouth (also called complete series) or Panoramic – 1 time per 12 month period.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per 12 months.

Fluoride Treatment (topical application or fluoride varnish). Covered 2 times per 12 month period.

Sealants. Covered once per 36 months for permanent first and second molars.

Space Maintainers. Covered 2 times per 12 month period, includes all adjustments within 6 months of installation.

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Fillings (restorations). Fillings are covered when placed on primary or permanent teeth. There are two kinds of fillings covered under this Plan:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If You choose to have a composite resin filling placed on a back tooth, We will pay up to the Maximum Allowed Amount for an amalgam filling. You will be responsible to pay for the difference, if the dentist charges more, plus any applicable Deductible or Coinsurance.

Endodontic Services

Endodontic Therapy

- Therapeutic pulpotomy. Covered on primary teeth. Will not be covered if given with root canal therapy.
- Pulpal therapy (anterior and posterior) primary teeth only.
- Partial pulpotomy for apexogenesis. Covered once per tooth per lifetime.
- Root canal therapy. Covered on permanent teeth. Covered once per tooth per lifetime.

Periodontal Services

Complex Surgical Periodontal Care. These services are surgical treatment for diseases of the gums (gingival) and bone that supports the teeth.

- Surgical revision (per tooth)

The following complex surgical periodontal care is covered once per quadrant per 12 months:

- Gingivectomy/gingivoplasty
- Gingival flap procedure
- Osseous surgery

The following complex surgical periodontal care is covered once per 12 months:

- Apically positioned flap
- Crown lengthening
- Surgical revision procedure (per tooth)
- Bone replacement graft (per site)
- Pedicle soft tissue graft, autogenous and non-autogenous connective tissue graft, and free soft tissue graft
- Distal/proximal wedge

Periodontal Scaling and Root Planing. This is a non-surgical periodontal service to treat diseases of the gums (gingiva) and bone that supports the teeth. Covered once per quadrant per 12 months.

Periodontal Maintenance. Covered 2 times per 12 months.

Oral Surgery Services

Basic Extractions

- Removal of coronal remnants (retained pieced of the crown portion of the tooth) on primary teeth.
- Extraction of erupted tooth or exposed root.

Complex Surgical Extractions

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

Other Oral Surgery Procedures

Below is a listing of common oral surgery procedures that are submitted for claims payment. Additional oral surgery procedures are covered under this dental Plan. Your Dentist can send Us a Pretreatment Estimate should You require additional information regarding the costs associated with the additional covered oral surgery services.

- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Mobilization to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Brush biopsy
- Alveoplasty
- Incision and drainage of abscess, intraoral and extraoral and

- Frenulectomy

Intravenous Conscious Sedation. Local anesthesia or nitrous oxide is not covered.

Major Restorative Services

Gold foil restorations. Gold foil restorations are covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same maximum allowed amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable Deductible and Coinsurance.

Inlays Restorations. Covered once per 60 months.

Onlays and/or Permanent Crowns. To be covered, the permanent tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. Covered once per 60 months.

Recement an Inlay, Onlay or Crown. Covered 6 months after initial placement.

Core Build Up. Includes any pins. Covered once per 60 months.

Cast and Prefabricated Post and Core. Covered once per 60 months.

Recement Cast or Prefrabricated Post and Core. Covered 6 months after initial placement.

Additional procedure to construct new crown under existing partial framework. Covered once per 60 months.

Pin Retention. Covered once per 60 months.

Prefabricated or Stainless Steel Crowns. Covered once per 60 months.

Occlusal Guards. Covered 1 time per 12 months.

Prosthodontic Services

Dentures and Partials (Removable Prosthodontic Services). Covered once per 60 months. We will pay for either a complete or immediate denture per arch but not both.

Overdentures (Complete and Partial Upper and Lower). We will pay up to the maximum allowed amount for an upper and lower complete denture or partial denture. If You still choose to have an overdenture, You will have to pay the difference plus any Deductible and/or Coinsurance for the covered benefit.

Bridges (fixed prosthodontic services). Covered once per 60 months.

Tissue Conditioning

Reline and Rebase. Covered once per 12 months after 6 months have passed from the initial placement of the appliance.

Repairs and Replacement of Missing or Broken Artificial Teeth and Replacement of Broken Clasps. Covered once per 12 months after 6 months has passed from the initial placement of the appliance.

Add Tooth or Clasp to Existing Partial Denture (per tooth).

Replace All Teeth and Acrylic for Partial Dentures.

Bridge Repair. Covered once per 60 months.

Denture and Partial Adjustments. Covered once per 12 months after 6 months has passed since the initial placement of the appliance.

Recementation of Bridge (fixed prosthetic). Covered once per 12 months after 6 months from the initial placement of the appliance.

Implant Supported Fixed and Removable Prosthetics (crowns, dentures, partials and bridges). Covered once per 60 months.

Implant Services. All implant services listed below are covered once per 60 months:

- Surgical placement of implant body
- Implant maintenance procedure
- Repair of implant supported prosthesis
- Replacement of semi precision or precision attachment of implant supported prosthesis
- Implant removal
- Debridement and osseous contouring of a peri-implant defect
- Bone graft for repair of a peri-implant defect
- Radiographic / surgical implant index

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to Your dental provider about getting a pretreatment estimate for Your orthodontic treatment plan, so You have an idea upfront what the treatment and costs will be. You or Your dental provider should send it to Us so We can help You understand how much is covered by Your benefits.

Dentally Necessary Orthodontic Care. This Plan will only cover orthodontic care when it's dentally necessary. Dentally necessary criteria is described below:

A. Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors
B. Has a true anterior open bite that does not include:
    1. One or two teeth slightly out of occlusion
    2. Where the incisors have not fully erupted
C. Demonstrates a significant antero-posterior discrepancy (class II or III malocclusion that is comparable to at least one full tooth class II or III, dental or skeletal)
D. Has an anterior crossbite that involves:
    1. More than two teeth in crossbite
    2. Obvious gingival stripping
    3. Recession related to the crossbite
E. Demonstrates handicapping posterior transverse discrepancies which
    1. May include several teeth, one of which must be a molar
    2. Is handicapping in function as follows:
        - Functional shift
        - Facial asymmetry
        - Complete buccal or lingual crossbite
        - Speech concern
F. Has significant posterior open bite that does not involve:
    1. Partially erupted teeth
    2. One or two teeth slightly out of malocclusion
G. Has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention (does not apply to third molars)
H. Has extreme overjet in excess of 8 to 9 millimeters and one of the skeletal conditions specified in provisions A through G of this section
I. Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures, and does not include simple loss of teeth with no other affects
J. Has a congenital or developmental disorder giving rise to a handicapping malocclusion
K. Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach
L. Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation

How We Pay for Orthodontic Care. Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of Your treatment. In order for Us to continue to pay for Your orthodontic care You must have continuous coverage under this Contract.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental provider should submit the necessary forms telling us when Your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this Contract ends.

If Your orthodontic treatment is already in progress (the appliance has been installed) when You begin coverage under this Contract, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that You are given while covered under this Contract. We will not pay for any portion of Your treatment that was given before Your effective date under this Contract.

What Orthodontic Care Does NOT Include. The following is not covered as part of Your orthodontic treatment:

- Monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment.
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or Outpatient hospital expenses, unless covered by the medical benefits of this Contract.
- Repair of orthodontic appliances, such as functional appliances, palatal expanders, removable and fixed retainers.
- Replacement of lost or broken retainers.

Pediatric Vision Care

These vision care services are covered for Members until the end of the month in which they turn 21. To get Network benefits, use a Blue View Vision eye care provider. For help finding one, try “Find a Doctor” on Our website, or call Us at the number on Your ID card.

Routine Eye Exam

This Contract covers a complete routine eye exam with dilation as needed. The exam is used to check all aspects of Your vision.

Eyeglass Lenses

Standard plastic (CR39) eyeglass lenses up to 55mm are covered, whether they’re single vision, bifocal, trifocal (FT 25-28) progressive or lenticular.

There are a number of additional covered lens options that are available through Your Blue View Vision Provider. See the “Schedule of Cost-Shares and Benefits” for the list of covered lens options.

Frames

Your Blue View Vision Provider will have a collection of frames for You to choose from. They can tell You which frames are included at no extra charge — and which ones will cost You more.

Contact Lenses

Each year, You can get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options in a given year (replacement lenses will be covered if they are Medically Necessary). Your Blue View Vision Provider will have a selection of contact lenses for You to choose from. They can tell You which contacts are included at no extra charge – and which ones will cost You more. Benefits also include a contact lens fitting and evaluation.

Elective contact lenses are ones You choose for comfort or appearance.

Non-elective contact lenses are ones prescribed for certain eye conditions:

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

Note: We will not pay for non-elective contact lenses for any Member who’s had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

WHAT IS NOT COVERED (EXCLUSIONS)

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

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

We will not allow benefits for any of the following services, supplies, situations, or related expenses:

Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Ambulance services related to an emergency for transportation to a Hospital.

Medical Services

We will not allow benefits for any of the following services, supplies, situations, or related expenses:

Abortion. For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

Administrative Charges. Charges to complete claim forms, Charges to get medical records or reports, and Membership, administrative, or access fees charged by Physicians or other Providers. Examples include fees for educational brochures or calling You to give You test results.

Affiliated Providers. Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

After Hours or Holidays Charges. Additional charges beyond the Maximum Allowed Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

Allergy Tests/Treatment. The following services, supplies or care are not covered:

- IgE RAST tests unless intradermal tests are contraindicated.
- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
- Food allergy test panels (including SAGE food allergy panels).
- Services for, and related to, many forms of immunotherapy. This includes oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.
- Specific non-standard allergy services and supplies, including skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Antigen leukocyte cellular antibody test (ALCAT); or
- Cytotoxic test; or
- HEMOCODE Food Tolerance System; or
- IgG food sensitivity test; or
- Immuno Blood Print test; or
- Leukocyte histamine release test (LHRT).

Alternative/Complementary Medicine. For (services or supplies related to) alternative or complementary medicine. Services in this category include acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

Ambulance. Usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or Your home.

Armed Forces/War. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

Artificial/Mechanical Devices - Heart Condition. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

Autism Spectrum Disorders. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- For which the Member has no legal obligation to pay in the absence of this or like coverage;
- Provided to the Member by a publicly funded program;
- Performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; and
- For services provided by persons who are not licensed as required by law.

Bariatric Surgery. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

Before Effective Date or After Termination Date. Charges for care You get before Your Effective Date or after Your coverage ends, except as written in this Contract.

Charges Over the Maximum Allowed Amount. Charges over the Maximum Allowed Amount for Covered Services.

Clinical Trials. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- The Investigational item, device, or service; or
- Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Complications of Non-Covered Services. Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

Complications Resulting from Experimental/Investigative or non Medically Necessary Services or Treatment. Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

Corrective Eye Surgery. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

Cosmetic Services. Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

Counseling Services. Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

Court Ordered Care. For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

Custodial Care, Services/Care Other Facilities. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Custodial Care, convalescent care or rest cures.
- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

Dental Braces. For Dental braces except as specified in "Pediatric Dental Care" in the "What Is Covered" section.

Dental Implants. For Dental implants except as specified in “Pediatric Dental Care” in the “What Is Covered” section.

Dental Treatment. For dental treatment, regardless of origin or cause, except as specified in “Pediatric Dental Care” or “Dental Services” in the “What Is Covered” section. “Dental treatment” includes: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.

Dental X Rays, Supplies & Appliances. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as specified in “Pediatric Dental Care” or “Dental Services” in the “What Is Covered” section. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of immunosuppresives.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

Diagnostic Admissions. Inpatient room and board or any charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Durable Medical Equipment. Covered Services does not include Durable Medical Equipment except as specifically stated in the “Medical Supplies, Durable Medical Equipment and Devices” benefit under “What Is Covered”:

- Orthopedic shoes or shoe inserts, except as specifically stated under “What Is Covered”.
- Air purifiers, air conditioners, humidifiers.
- Exercise equipment, treadmills.
- Pools and spas.
- Elevators.
- Supplies for comfort, hygiene or beautification.
- Correction appliances or support appliances and supplies such as stockings.

Education/Training. For services or supplies primarily for educational, vocational, or training purposes, except as specified in “Habilitative Services” in the “What Is Covered” section of this Contract.

Environmental Change. For admission as an Inpatient for environmental change.

Exams - Research Screenings. For examinations relating to research screenings.

Experimental/Investigative. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be experimental/Investigative.

Experimental/Investigative Services exclusions. Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or

- is 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
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, 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.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive.

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Eyeglasses/Contact Lenses. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated in “Pediatric Vision Care” in the “What Is Covered” section of this Contract. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

Family/Self. Prescribed, ordered or referred by, or received from a member of Your immediate family, including Your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

Feet - Surgical Treatment. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

Foot Care – Routine. For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including:

- cleaning and soaking the feet
- applying skin creams in order to maintain skin tone
- other services that are performed when there is not a localized illness, injury or symptom involving the foot

Gene Therapy. Gene Therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Government Coverage. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

Gynecomastia. For surgical treatment of gynecomastia.

Hair loss or growth treatment. Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Health Club Memberships and Fitness Services. Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Home Care. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider, except for Hospice Care (see the “Hospice Care” benefit under “What Is Covered”).
- Food, housing, homemaker services and home delivered meals with the exception of Medically Necessary enteral and parenteral formulas.
- Personal Comfort items.

Hospice (Care). We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed in the “What Is Covered” section or for dietary counseling, even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

Human Growth Hormone. Human Growth Hormone.

Hyperhydrosis. For treatment of hyperhydrosis (excessive sweating).

Impotency. For services and supplies related male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

Incarceration. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, if the Member has been convicted as a felon. This exclusion does not apply to a Member while incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.

Infertility Testing and Treatment. For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis.

Maintenance Therapy. Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps You keep Your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What Is Covered" section.

Mandibular Augmentation/Implant Procedures. For mandibular augmentation/implant procedures to facilitate the use of full or partial dentures, prosthesis fixed or removable, or for mandibular atrophy regardless of Medical Necessity.

Manipulation Therapy – Home. For Manipulation Therapy services rendered in the home unless specifically stated as covered under the "Home Care Services" benefit in the "What Is Covered" section.

Medical Equipment, Devices, and Supplies. We do not provide benefits for supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Medicare Benefits. (1) for which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A and B, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

Missed/Cancelled Appointments. For missed or cancelled appointments.

No legal obligation to pay. For which You have no legal obligation to pay in the absence of this or like coverage.

Non Authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service in "Transportation and Lodging" under the "What Is Covered" section.

Non-Chemical Addictions. For treatment of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

Non-Emergency Care Received in Emergency Room. For care received in an Emergency Room that is not Emergency Care, except as specified in "Emergency Care Services" in the "What Is Covered" section of this Contract. This includes suture removal in an Emergency Room.

Not Medically Necessary. Any services or supplies which are not Medically Necessary.

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as provided in "Home Care Services", "Hospice Services", or "Hospital Services" under "What Is Covered " section or as required by law. This exclusion includes, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

Orthodontic Services. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Monthly treatment visits that are inclusive of treatment cost;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;

- Inpatient or outpatient hospital expenses (please refer to Your medical coverage to determine if this is a covered medical service).

Orthotic Devices. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.
- Orthopedic shoes.
- Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
- Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
- Garter belts or similar devices.

Outdoor Treatment Programs and/or Wilderness Programs.

Over the Counter. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated in the "Prescription Drug" benefit under the "What Is Covered" section, or as required by law.

Personal Hygiene, Environmental Control or Convenience Items. For personal hygiene, environmental control, or convenience items including:

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; 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 or similar facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

Physical exams and immunizations - other purposes. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

Physician Stand-by Charges. For stand-by charges of a Physician.

Physician/Other Practitioners' Charges. Physician or Other Practitioners' charges including:

- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member, except as provided in "Telehealth" in the "What is Covered" section.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.

- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include fees charged for educational brochures or calling a patient to provide their test results.

Private Duty Nursing. For Private Duty Nursing Services unless specified in "Home Care Services" in the "What Is Covered" section.

Provider Services. You get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such Providers may include masseurs or masseuses (massage therapists) and physical therapist technicians.

Provider Type. Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

Reconstructive Services. Reconstructive services except as specifically stated in "Reconstructive Surgery" in the "What Is Covered" section, or as required by law.

Regression Prevention. For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable, except as specified in "Habilitative Services" in the "What Is Covered" section.

Reversal of Sterilization. For reversal of sterilization.

Riot, Nuclear Explosion. For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

Self-Help Training/Care. For self-help training and other forms of non-medical self care, except as specified in "Diabetes Services", "Maternity and Reproductive Health Services", "Other Therapy Services" or "Mental Health and Substance Abuse Services" in the "What Is Covered" section of this Contract.

Shock Wave Treatment. Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

Spinal Decompression Devices. Spinal decompression devices. This includes Vertebral Axial Decompression (Vax-D) and DRX9000.

Surrogate Pregnancy. Services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, the bearing of a child by another woman for an infertile couple).

Teeth - Congenital Anomaly. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in "Dental Services" in the "What Is Covered" section or as required by law.

Teeth, Jawbone, Gums. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated in "Dental Services" as a Covered Service under the "What Is Covered" section.

Telephone/Internet Consultations. For telephone consultations or consultations via electronic mail or internet/web site, except as specified in "Telehealth" in the "What Is Covered" section of this Contract.

Therapy – Other. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Gastric electrical stimulation
- Hippotherapy
- Intestinal rehabilitation therapy
- Prolotherapy
- Recreational therapy
- Sensory integration therapy (SIT)

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Exclusions. Non-Covered Services for transportation and lodging include:

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

Unlisted services. Services not specifically stated in this Contract as Covered Services unless a covered essential health benefit.

Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

Vision Orthoptic Training. For orthoptics or vision training and any associated supplemental testing.

Waived Copayment, Coinsurance, or Deductible. For any service for which You are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

Weight Loss Programs. For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract in the “What Is Covered” section. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Workers Compensation. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker’s Compensation Act or other similar law. If Worker’s Compensation Act benefits are not available to You, then this exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third

Prescription Drugs

Your Prescription Drug benefits do not include or cover:

- Administration Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives. Certain Prescription Drugs may not be covered if You could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give You similar results for a disease or condition. If You have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of Your Identification Card, or visit Our website at www.anthem.com.
  If You or Your Doctor believes You need to use a different Prescription Drug, please have Your Doctor or pharmacist get in touch with Us. We will cover the other Prescription Drug only if We agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
- Drugs Prescribed by Providers Lacking Qualifications/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications as determined by Anthem.
- Gene Therapy as well as any Drugs, procedures, health care services related to it, that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
- Compound Drugs.
- Contrary to Approved Medical and Professional Standards. Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs You take at the time and place where You are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- Drugs Over Quantity or Age Limits. Drugs in quantities which are over the limits set by Anthem BCBS, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs. Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service. Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Drugs not approved by the FDA.
- Off label use. Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Onchomycosis Drugs. Drugs for Onchomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.

- Over-the-Counter Items. Drugs, devices and products, or Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sexual Dysfunction Drugs. Drugs to treat sexual or erectile problems.
- Syringes. Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs. Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

Pediatric Dental Care

Your dental care services do not include services incurred for or in connection with any of the items below:

- Dental Care for Members age 21 and older.
- Services of anesthesiologist, unless required by law.
- Anesthesia Services, (such as intravenous or non-intravenous conscious sedation and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case presentations, office visits, consultations.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Contract.
- Separate services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, elective or enhanced prosthodontic procedures including connector bar(s) and precision attachments.
- Placement or removal of sedative filling, base or liner used under a restoration that is billed separately from a restoration procedure (such as a filling).
- Pulp vitality tests.
- Incomplete root canals.
- Cone beam images.
- Sinus augmentation.
- Oral hygiene instructions.
- Replacement of lost or broken appliances.
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- For dental services received prior to the effective date of this Contract or received after the coverage under this Contract has ended.
- Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
- Dental services for which You would have no legal obligation to pay in the absence of this or like coverage.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.

Pediatric Vision Care

Your vision care services do not include services incurred for or in connection with any of the items below:

- Vision care for Members age 21 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse or Domestic Partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- Visual therapy, such as orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including Inpatient or Outpatient Hospital vision care, except as specified in "Pediatric Vision Care" in the "What Is Covered" section of this Contract.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements; this exclusion does not apply to one set of replacement lenses or frames if they are Medically Necessary.
- For services or supplies not specifically listed in this Contract.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Contract.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of Our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

CLAIMS PAYMENTS

This section describes how Your claims are administered, explains the cost-sharing features of Your Plan, and outlines other important provisions. The specific cost sharing features, and the applicable benefit percentages and/or limitations, are outlined in the "Schedule of Cost-Shares and Benefits" section.

We consider Covered Services to be incurred on the date a service is provided. This is important because You must be actively enrolled on the date the service is provided.

Maximum Allowed Amount

General

This provision describes how We determine the amount of reimbursement for Covered Services.

Reimbursement for services rendered by Network and Non-Network Providers is based on Your Contract's Maximum Allowed Amount for the Covered Service that You receive. Please also see the "Inter-Plan Programs" provision for additional information.

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

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

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

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

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

Provider Network Status

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

A Network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Contract is the rate the Provider

has agreed with Us to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding a Network Provider or visit Our website www.anthem.com.

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

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

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

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

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

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

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

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

Member Cost Share

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

Your Cost-Share amount and Out-of-Pocket Maximum may vary depending on whether You received services from a Network or Non-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Non-Network Providers. Please see the "Schedule of Cost-Shares and Benefits" in this Contract for Your Cost-Share responsibilities and limitations, or call Member Services to learn how this Contract's benefits or Cost-Share amounts may vary by the type of Provider You use.

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

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

The following are examples for illustrative purposes only; the amounts shown may be different than this Contract's Cost-Share amounts; see Your "Schedule of Cost-Shares and Benefits" for Your applicable amounts.

Example: Your plan has a Coinsurance Cost-Share of 20% for Network services, and 30% for Non-Network services after the Network or Non-Network Deductible has been met.

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

- The Non-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; Your Coinsurance responsibility is 20% of $950, or $190 and the remaining allowance from Us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, Your total out-of-pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.
- You choose an Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; Your Coinsurance responsibility when an Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out-of-pocket responsibility would be $300.
- You choose a Non-Network surgeon. The Non-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; Your Coinsurance responsibility for the Non-Network surgeon is 30% of $1500, or $450 after the Non-Network Deductible has been met. We allow the remaining 70% of $1500, or $1050. In addition, the Non-Network surgeon could bill You the difference between $2500 and $1500, so Your total out-of-pocket charge would be $450 plus an additional $1000, for a total of $1450.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, We may authorize the Network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Non-Network Provider. In such circumstances, You must contact Us in advance of obtaining the Covered Service. We also may

authorize the Network Cost-Share amounts to apply to a claim for Covered Services if You receive Emergency services from a Non-Network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Member Services for authorized services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Contract's Cost-Share amounts; see Your "Schedule of Cost-Shares and Benefits" for Your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no Network Provider for that specialty in Your State of residence. You contact Us in advance of receiving any Covered Services, and We authorize You to go to an available Non-Network Provider for that Covered Service and We agree that the Network Cost-Share will apply.

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

Because We have authorized the Network Cost-Share amount to apply in this situation, You will be responsible for the Network Copayment of $25 and We will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

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

Deductible Calculation

Each family Member's Maximum Allowed Amounts for Covered Services is applied to his or her individual Deductible. Once two or more family Members' Maximum Allowed Amounts for Covered Services combine to equal the family Deductible, then no other individual Deductible needs to be met for that Calendar Year. No one person can contribute more than his or her individual Deductible to the family Deductible.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how Your plan works, please refer to the "Schedule of Cost-Shares and Benefits".

The Deductible and Copayment/Coinsurance amounts incurred in a Calendar Year apply to the Out-of-Pocket Limit.

The Network and Non-Network Deductibles are separate and do not apply toward each other.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a Calendar Year apply to the Out-of-Pocket Limit.

The individual Out-of-Pocket Limit applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year. No one person can contribute more than his or her individual Out-of-Pocket Limit.

Once the applicable Network Out-of-Pocket Limit is satisfied, no additional Network Cost Sharing will be required for the remainder of the Calendar Year.

Once the applicable Non-Network Out-of-Pocket Limit is satisfied, no additional Cost-Sharing will be required for the remainder of the Calendar Year except for Non-Network Human Organ and Tissue Transplant services and any charges over the Maximum Allowed Amount.

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

The Non-Network Out-of Pocket Limit does not include Coinsurance for any Non-Network Human Organ Tissue Transplant.

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that You pay toward Your health care costs are counted toward Your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once Your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include:

- amounts over the Maximum Allowed Amount;
- amounts over any policy maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

When You receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

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

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

pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

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

B. Special Cases: Value-Based Programs

BlueCard Program

If You receive Covered Services under a value-based program inside a Host Blue's service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

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

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

D. Nonparticipating Providers Outside Our Service Area

1. **Allowed Amounts and Member Liability Calculation**

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

2. **Exceptions**

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

E. BlueCard Worldwide® Program

If You plan to travel outside the United States, call Member Services to find out Your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. The plan only covers Emergency, including ambulance, and Urgent Care outside of the United States. Remember to take an up to date health ID card with You.

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

Keep in mind, if You need emergency medical care, go to the nearest hospital. There is no need to call before You receive care. Please refer to the "Requesting Approval for Benefits" section.

How Claims are Paid with BlueCard Worldwide

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

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

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When You need BlueCard Worldwide claim forms You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

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

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network/participating or Non-Network Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for Your Cost-Share responsibilities and limitations, or call Member Service to learn how this Plan's benefits or Cost-Share amounts may vary by the type of Provider You use.

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

In some instances, You may only be asked to pay the lower Network Cost-Sharing amount when You use a Non-Network Provider. For example, if You go to a Network/participating Hospital or Provider Facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network Cost-Share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

How to Obtain Benefits

When You receive care through a Network Provider, You are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

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

Payment Innovation Programs

We pay Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) - may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by Us from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to Us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Health Care Services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any

Copayment or Coinsurance amounts related to payments made by Us or to Us under the Program(s), and You do not share in any payments made by Network Providers to Us under the Program(s).

Relationship of Parties (Anthem and Network Providers)

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

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

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

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMCSO), as having a right to enrollment under the Subscriber's Contract), or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by ERISA or applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Services Performed During Same Session

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

Assignment

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

If Prescription Drugs are provided by a licensed pharmacist, We will recognize a valid assignment by You to the pharmacist of Your right to receive payment for the Prescription Drugs subject to the following conditions:

The claim must provide all of the information specified above, and Our payments must not have been made to You prior to Our receipt of the assignment.

Payment Owed to You at Death

Any benefits owed at Your death will be paid to Your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

When a claim is paid, any Premium due may be deducted from the claim payment.

Notice of Claim

We are not liable under this Contract unless We receive written notice that Covered Services have been given to You. An expense is considered incurred on the date the service or supply was given.

The notice must be given to Us within 90 days of receiving the Covered Services and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision, or no benefits will be payable.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

Failure to give Us notice within 90 days will not reduce any benefit if You show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the usual 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Note: You have the right to obtain an itemized copy of Your billed charges from the Hospital or facility that provided services.

Claim Forms

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

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

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program that would have primary responsibility for benefits. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Time of Payment of Claims

Claims will be paid within thirty (30) calendar days from the date that the claim is received by Us.

Explanation of Benefits (EOB)

After You receive medical care, You will receive an explanation of benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill but a statement from Us to help You understand the coverage You are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by Your coverage.
- The amount for which You are responsible (if any).
- General information about Your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

IF YOU ARE COVERED BY MORE THAN ONE POLICY

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

Please note that several terms specific to this provision are listed below. For this provision, the terms below will have the meanings, as describe in this section. Some of these terms may have different meanings, in other parts of the Contract. In the rest of the Contract, the meaning of a term can be determined based on the Definition Section, provided at the end of this Contract.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable Expense.

Coordination of Benefits Definitions

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); and Medicare or any other federal governmental plan, as permitted by law.
2) Plan does not include: 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 benefits under group or individual “no-fault” and traditional “fault” type automobile contracts; 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.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is Primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is Secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense is a health care expense, including Deductibles, Coinsurance and Copayments that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable Expense.

The Allowable Expense under COB is generally the higher of the Primary and Secondary Plans’ allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment

under the higher of the Plans' allowable amounts. This higher allowable amount may be more than Our Maximum Allowed Amount.

The following are not Allowable Expenses:

(1) The difference between the cost of a semi-private hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

(3) If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a Member has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

(6) The amount that is subject to the Primary high-deductible health Plan's Deductible, if We have been advised by You that all Plans covering You are high-deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

(7) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed Panel Plan is a Plan that provides health care benefits primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Claim Determination Period - means a period of at least twelve (12) consecutive months, over which Allowable Expenses shall be compared with total benefits payable in the absence of Coordination of Benefits, to determine whether overinsurance exists and how much each Plan will pay or provide.

Benefit Reserve - means the savings recorded by a Plan for claims paid for a Member as a Secondary Plan rather than as a Primary Plan.

Order of Benefit Determination Rules

When You are covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

Except as provided in the paragraph below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is Secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule (1) Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers You as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

Rule (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

(A.) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(B.) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, Rule (2)(A) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, Rule (2)(A) above shall determine the order of benefits; or
- If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The Plan covering the Custodial parent;
    - The Plan covering the spouse of the Custodial parent;
    - The Plan covering the non-Custodial parent; and then
    - The Plan covering the spouse of the non-Custodial parent.

(C.) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, Rule (2)(A) or Rule (2)(B) above shall determine the order of benefits as if those individuals were the parents of the child.

Rule (3) Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other

Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if Rule (1) above can determine the order of benefits.

Rule (4) COBRA or State Continuation Coverage. If You are covered under COBRA or under a right of continuation provided by state or other federal law, the Plan covering You as an employee, member, subscriber or retiree or covering the person as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if Rule (1) above can determine the order of benefits.

Rule (5) Longer or Shorter Length of Coverage. The Plan that covered You as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule (6) If the preceding rules do not determine the order of benefits, the Allowable Expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefit of This Plan

When This Plan is Secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim.

Because the Allowable Expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If You are enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Plan and other Closed Panel Plans.

When This Plan is Secondary, You will receive credit during the calendar year for the amount by which Your benefits are reduced. This credit will not be applied to the extent that would cause You to receive:

1) A combined benefit from all Plans greater than the Allowable Expense; or
2) More benefits during a calendar year than You would receive if there were no other coverage.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If This Plan is Secondary, any Benefit Reserve accumulated for a Member will be used to pay Allowable Expenses of that Member only, not otherwise paid during the Claim Determination Period. The Benefit Reserve, if any, will return to zero at the end of the Claim Determination Period.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination with Medicare

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

Except when federal law requires the Plan to be the primary payor, the benefits under This Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which members are entitled under Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purpose of the calculation of benefits, if the Member has not enrolled in the Medicare Part B, We will calculate benefits as if they had enrolled.

IF YOU HAVE A COMPLAINT OR AN APPEAL

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

(If You need assistance in Spanish to understand this document, You may request it for free by calling Member Services at the number on Your Identification Card.)

We want your experience with Us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Service by calling the number on the back of your Identification card. Our Member Service representatives are specially trained to answer Your questions about Our health Plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Deductible, Coinsurance, or Copayment amounts;
- Specific claims or services You have received;
- Doctors or Hospitals in the Network;
- Authorizations; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe Your rights under the Appeals process. A complaint Process also exists to help You understand the Plan's determinations.

The Complaint Process

A complaint process is available to provide reasonable, informative responses to complaints that You may have about Us. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from Us of Our procedures and contracts. We invite You to share any concerns that You may have over benefit determinations, coverage terminations, or the quality of care rendered by Providers in Our Networks.

If You have a complaint or problem concerning benefits or services, please contact Us. Please refer to Your Identification Card for Our address and telephone number. You may send in Your complaint by letter or by phone call. Or, if You wish, You may meet with Your local service representative to discuss Your complaint. Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which Appeals must be filed.

The Appeals Process

An Appeal is a formal request from You that asks Us to change a previous determination. If You are notified in writing of any Adverse Determination or Coverage Denial, You will be advised of Your right to an internal Appeal and an external review if appropriate. You also have a right to Appeal if We fail to make a Utilization Review determination and provide written notice within the required time frame. For purposes of this section:

- Coverage Denial means Our determination that a service, treatment, drug or device is specifically limited or excluded under this Contract.
- Adverse Determination means Our denial, reduction, or termination of a benefit (either in whole or in part) based on any of the following:
    - A determination that You are not eligible to participate in the Plan, including the denial, reduction, or termination of a benefit (in whole or in part) as a result of a utilization review;
    - A determination that the benefit is Experimental / Investigative or not Medically Necessary;
    - A determination that the benefit is not a covered benefit under the plan; or

    - A determination that the benefit is excluded due to a source-of-injury exclusion, network exclusion, or other limitation in the plan.
- Adverse Determination includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit.

The internal Appeals process may be initiated by the You, Your authorized representative, or a Provider acting on Your behalf within 60 days of the date you get Our written notice of an Adverse Determination, a Coverage Denial or any other adverse decision We made, but must be filed within six months of the date you get the initial decision. The request should include any medical information pertinent to the Appeal. All portions of the medical records that are relevant to the Appeal and any other comments, documents, records or other information submitted by You relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the Appeal. Any new medical information pertinent to the Appeal will also be considered. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Appeal.

In addition, We will also provide You, free of charge, with any new or additional evidence We will consider, rely upon, or generate in connection with the claim, as well as Our rationale for making any Adverse Determination. We will provide this as soon as possible and sufficiently in advance of the date on which the final Adverse Determination is due, by law, to give You a reasonable opportunity to respond prior to that date.

You will continue to get coverage under the Plan pending the outcome of the internal Appeal, as long as You remain eligible for coverage. If You have undertaken an ongoing course of treatment, We will only reduce or terminate it after giving you advance notice.

If a representative is seeking an Appeal on Your behalf, We must get a signed Designation of Representation (DOR) form from You. The Appeal process will not begin until We get the properly completed DOR form. The only exception to this is if a Physician requests an expedited internal Appeal on Your behalf, the Physician will be deemed to be Your representative for the purpose of filing the expedited internal Appeal even though We did not get the signed form. We will forward a Designation of Representation form to You to complete in all other situations.

We will ensure that Appeals are reviewed in a manner designed to ensure the independence and impartiality of the individuals responsible for reviewing Your request (referred to as qualified reviewers). The qualified reviewers will not be the same people who made the initial denial or determination. They will not be the subordinates of the initial decision maker either and no deference will be given to the initial decision. If the internal Appeal is related to an Adverse Determination or any other adverse decision that is based in whole or in part on a medical judgment, at least one person conducting the Appeal will be a licensed Physician (or if the determination involves services rendered by a Chiropractor or Optometrist, a Chiropractor or Optometrist licensed in Kentucky) unless a nurse can approve the request. If the Appeal is related to a medical or surgical specialty or subspecialty, upon Your request, the request of Your authorized representative or Your Provider, at least one person conducting the Appeal will be a board eligible or certified Physician in the appropriate specialty or subspecialty.

Within a reasonable time given the medical circumstances and no later than 30 days after We get a written or an oral request for Appeal, We will send a written decision to You or Your authorized representative and, if applicable, Your Provider.

If We fail to resolve the Appeal within the required time, You may pursue external review as described later in this section. This option is not available, however, if Our failure to resolve the Appeal is due to a de minimus violation that does not cause harm to You or is not likely to cause prejudice or harm to You, if the delay is for good cause or due to matters beyond Our control, and is part of an ongoing, good faith exchange of information between You and Us.

Please refer to the “Prescription Drug List” subsection under the “Prescription Drugs” section for the process for submitting an exception request for Drugs not on the Prescription Drug List.

Expedited Appeals

An expedited Appeal is deemed necessary when You are hospitalized, or in the opinion of the treating Provider (or any Physician with knowledge of Your medical condition), review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing Your health or, with respect to a pregnant woman, Your health or Your unborn child in serious jeopardy;
- Subjecting You to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions;
- Serious dysfunction of a bodily organ or part; or
- Any claim that a Physician with knowledge of Your medical condition determines is a claim involving urgent care.

In addition, Members in urgent care situations and Members receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal Appeals process.

The Plan, applying a prudent lay person standard, may also determine that an Appeal may be expedited. The request for an expedited internal Appeal may be in writing or an oral request, followed up by an abbreviated written request by You, Your authorized representative or Provider acting on Your behalf. We have the right to require verification from the treating Provider (or other Physician with knowledge of Your medical condition), that Your condition warrants an expedited internal Appeal.

The process for the expedited internal Appeal is similar to the standard internal Appeal, except that We will communicate Our decision to You or Your authorized representative as soon as possible taking into account the medical urgency of the situation, but no later than 72 hours after receipt of the request for an expedited internal Appeal. All necessary information, including Our decision on review, shall be transmitted between Us and You or Your authorized representative by phone, facsimile, or other available similarly expeditious method.

If Our decision is to uphold a Coverage Denial, You, Your authorized representative or a Provider acting on behalf of and with our consent may contact the Kentucky Department of Insurance, Health and Life Division, 215 W. Main Street, P.O. Box 517, Frankfort, KY 40602, and request a review of Our decision. The Department will make a determination as to whether the service should or should not be covered. If the Department determines the disputed service should be covered, it may direct Us to either pay the service or offer external review to resolve the issue.

External Review by an Independent Review Entity

You, Your authorized representative, or a Provider acting on your behalf and with your consent may request an external review of an Adverse Determination if the following criteria are met:

- The internal Appeal process outlined above was completed or jointly waived by you and Us or We failed to make a decision within 30 days of receiving the written Appeal or within 72 hours of receiving the request for an expedited Appeal; and
- You were covered under this Contract on the date of service or, if a prospective denial, You were eligible to receive benefits under this Contract on the date the proposed service was requested.

The request for an external review of an Adverse Determination must be sent to Us within 4 months of the date you get Our written decision rendered under the internal Appeals process. As part of the request, You shall provide written consent authorizing the independent review entity to get all medical records from Us and any Provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

We will determine if Your request qualifies for independent review and will refer all eligible requests to the Kentucky Department of Insurance, who will assign an independent review entity. Independent review entities are assigned on a rotating basis so that We do not have the same independent review entity for

two consecutive external reviews. We will inform You in writing of the independent review entity that will conduct the review and inform You of their right to submit additional information to the independent review entity within 5 days. If the independent review entity receives the information within 5 days they will include it in their review and forward a copy to Us within one day. We will also forward all information required to be considered for an external review to the independent review entity within three business days of assignment.

You will be assessed a filing fee of $25 to be paid to the independent review entity. This fee may be waived if the independent review entity determines that the fee creates a financial hardship on You. The fee shall be refunded if the independent review entity finds in favor of You. If You send in multiple requests for external review within a one-year period, You will not have to pay more than $75 per year in filing fees. We will be responsible for the rest of the cost of the external review.

The independent review entity will send a written decision to You within 21 days from the date they get all of the information required from Us. An extension of up to 14 days may be allowed if agreed to by You and Us. In no event will the independent review entity take longer than 45 days to complete their review.

You will not be able to get an external review of an Adverse Determination if:

- Your Adverse Determination has previously gone through the external review process and the independent review entity found in Our favor; and
- No new relevant new clinical information has been sent to Us since the independent review entity found in Our favor.

If a dispute arises between You and Us about the right to an external review, You may file a complaint with the Kentucky Department of Insurance. Within five days of the date they get Your complaint, the Department will make a decision. They may direct Us to send the dispute to an independent review entity for an external review if they find that the dispute involves denial of coverage based on Medical Necessity or the service being Experimental/Investigative and all other external review requirements have been met.

Expedited External Reviews

External reviews shall be done in an expedited manner by the independent review entity if You are hospitalized, or if, in the opinion of the treating Provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing Your health or, with respect to a pregnant woman, Your health or the health of Your unborn child in serious jeopardy;
- Subjecting You to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

Expedited reviews are also available if You are requesting review of a decision that a recommended or requested service is Experimental/Investigative and Your Physician certifies in writing that the requested service would be significantly less effective if not promptly initiated.

Members may pursue an expedited external review while simultaneously pursuing an expedited internal Appeal.

The request for an expedited external review may be in writing or an oral request, followed up by an abbreviated written request, by You, Your authorized representative or a Provider acting on Your behalf with Your consent. Requests for expedited external review shall be sent by Us to the independent review entity within 24 hours of receipt. We will call the independent review entity to confirm that a specialist is available and that the review has been accepted.

For expedited external review, a decision shall be made by the independent review entity within 24 hours of getting all information required from Us. An extension of up to 24 hours may be allowed if agreed to by You and Us. We will provide notice to the independent review entity and to You by the same day that the Adverse Determination has been assigned to an independent review entity for expedited review. In no event will the independent review entity take longer than 72 hours to complete their review.

The Decision of the Independent Review Entity

The independent review entity shall provide to You, Your treating Provider, the Kentucky Department of Insurance and Us a decision which shall include:

- The findings for either Us or You regarding each issue under review;
- A summary of the proposed service, treatment, drug, device or supply for which the review was performed;
- The relevant provisions in the Contract and how they were applied; and
- The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

Records provided to independent review organizations are handled as confidential records.

The decision of the independent review entity will be binding on Us and You except to the extent that there are remedies available under applicable state or federal law.

Contact Person For Appeals

The request for an internal Appeal or an external review and supporting documentation must be submitted to the following address or to the Appeal address or telephone number provided on Your written notice of an adverse decision:

Anthem Blue Cross Blue Shield
P.O. Box 105568
Atlanta, GA 30348-5568

We encourage You to submit any requests for Appeals or external review in writing. The request should describe the problem in detail. Please attach copies of bills, medical records, or other appropriate documents to support Your position.

You must file Appeals on a timely basis. You are encouraged to file internal Appeals within 60 days of the date You get Our initial decision, and must file internal Appeals within six months of the date You get Our initial decision. If the right to external review exists as described above, You must file the external review request within 4 months of the date You received Our final decision on Your internal Appeal.

Dental Coverage Appeals

Please submit Appeals regarding Your dental coverage to the following address:

Anthem Blue Cross and Blue Shield
P. O. Box 1122
Minneapolis, MN 55440-1122

Blue View Vision Coverage Appeals

Please submit Appeals regarding Your vision coverage to the following address:

Blue View Vision
555 Middle Creek Parkway
Colorado Springs, CO 80921

Medical Services

We are not liable for Covered Services that You do or do not get from a Provider. You shall have no claim against Us for acts or omissions of any Provider from whom You receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to You.

Limitation of Actions

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

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2. Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic Plan;
3. Be a United States citizen or national; or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. Be a resident of the Commonwealth of Kentucky and meet the following applicable residency standards:

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution;
- Be capable of indicating intent;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange.

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution;
- Not be emancipated;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange.

6. Agree to pay for the cost of Premium that Anthem requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B and/or D;
10. Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1. resides, intends to reside (including without a fixed address); or
2. has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard.

Dependent Eligibility

To be eligible for coverage to enroll as a Dependent, You must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1. The Subscriber's legal spouse.
2. The Subscriber's Domestic Partner - Domestic Partner or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a. For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b. A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c. To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3. The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26.
4. Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any Dependent. Your failure to provide this information could result in termination of a Dependent's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost-Sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move, provided he or she had Minimum Essential Coverage in effect for one or more days of the 60 days prior to the move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth, including 5 days of nursery care for a well newborn. To continue coverage beyond the first 31 days, please contact the Exchange within 60 days of the date of birth to add the child to the Subscriber's Contract, and You must pay Anthem timely for any additional Premium due.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to You. The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption. Please contact the Exchange within 60 days of the placement for adoption or date of adoption to add the child to the Subscriber's Contract, and You must pay Anthem timely for any additional Premium due.

Adding a Child due to Filing an Application for Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange

within 60 days of the date of the filing of the application for appointment of guardianship. Coverage will be effective on the date of the filing of the application for appointment of guardianship.

Court Ordered Health Coverage

If You are required by a court order, as defined by applicable state or federal law, to enroll Your child under this Contract, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Contract and once approved by the Exchange, We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent age limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. The applicant's Effective Date is determined by the Exchange based on the receipt of the completed enrollment form. Benefits will not be provided until the applicable Premium is paid to Anthem.

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption unless the Subscriber timely requests a different Effective Date. Advance payments of the premium tax credit and Cost-Sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month;
2. In the case of marriage, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within 60 days of the event; and
3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective based on when a complete application is received, which must be within 60 days of the qualifying event.

Effective dates for special enrollment due to loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
   - Individual who no longer resides, lives or works in the Plan's Service Area,
   - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
   - Termination of employer contributions, and
   - Exhaustion of COBRA benefits.

Effective dates for special enrollment due to loss of Minimum Essential Coverage do not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member may result in termination or rescission of coverage.

WHEN MEMBERSHIP ENDS (TERMINATION)

This section describes how coverage for a Member can be terminated, cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his or her coverage with appropriate notice to the Exchange;
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, moves outside the Service Area, etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date);
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage;
5. The QHP terminates or is decertified;
6. The Member changes to another QHP; or
7. The QHP issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1. The 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2. Any other applicable grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
   a) The termination date specified by the Member, if reasonable notice is provided;
   b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
   c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4. In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium is paid, consistent with existing State laws regarding grace periods. We will provide the Subscriber 30 day's written notice of cancellation for nonpayment of Premium by regular, first class mail.

6. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7. The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

"Reasonable notice" is defined as fourteen days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continues to be met.
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract.
3. This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP issuer any information requested regarding Your eligibility and the eligibility of Your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependent did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give You at least 30 days written notice prior to rescission of this Contract.

This Contract may also be terminated if You engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if You knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following Your Effective Date, We may only rescind or terminate Your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Coverage

We can refuse to renew Your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide You with at least 90 days notice of the discontinuation. In addition, You will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required premium by the end of the grace period, the Contract is terminated. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's premium in a Calendar Year, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to terminate the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium is due You give timely written notice to Us that the Contract is to be terminated. If You do not make the full Premium payment during the grace period, the Contract will be terminated on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the last day through which Premium is paid.

After Termination

Once this Contract is terminated, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may terminate the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

Reinstatement

If Your Contract has been terminated for non-payment, We may reinstate Your coverage or We may decline to reinstate Your coverage. We have the right to require an application for Reinstatement and issue a conditional receipt for the Premium. If You have not been notified in writing, within 45 days of the date of the conditional receipt, of Our disapproval of Your application for Reinstatement, Your Contract will be reinstated on the 45th day following the date of the conditional receipt.

Premium accepted in connection with a Reinstatement will not be applied to a period more than 60 days prior to the date of Reinstatement.

If We fail to provide You with a 30 day written notice of Our termination, coverage will remain in effect at the existing Premium until 30 days after the notice is given or the effective date of replacement coverage obtained by the Subscriber, whichever occurs first.

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

Administrative Fee

An administrative fee of $20 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

Care Coordination

We pay Network Providers in various ways to provide Covered Services to You. For example, sometimes We may pay Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, We may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, We may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to Us because they did not meet certain standards. You do not share in any payments made by Network Providers to Us under these programs.

Changes in Premiums

The rates are guaranteed for the twelve (12) month period following the first day of the calendar year. The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a proposed Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Contract Modifications

The Plan reserves the right to change the benefit provision effective on your renewal date, and the terms and conditions thereof, provided for under this Contract by giving written notice to the Subscriber not less than 30 days prior to the Effective Date of such change; however, such notice requirement shall not apply to changes in benefits provisions that are required by state or federal law.

Effective Date of Contract

Coverage begins for the persons covered under this Contract on the Effective Date stated in the Anthem Welcome Letter, and such letter is incorporated herein by reference.

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and, as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

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

Form or Content of Contract

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

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a Premium bill from Anthem, you are still obligated to pay, at a minimum, the amount of the prior Premium bill.

In the event that there are insufficient funds in your account to cover the amount of your Premium payment at the time your payment is presented to your financial institution, a fee may appear on a subsequent Premium notice to satisfy the fee charged for insufficient funds.

The Member's monthly Premium for this Contract is stated in the Anthem Welcome Letter. The Contract between Us and the Subscriber includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders and your Anthem Welcome Letter. Please keep the letter and attach it to your Contract.

The amount of Premium is also printed on your Premium notice; however, this amount is subject to change as allowed by law. We will not increase Premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new Premium amount.

If a Premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be terminated at the end of the Grace Period and you will receive a refund of any unearned Premium.

If a decrease in Premium is appropriate, We will adjust what is owed to Us and let you know the new amount of Premium due. We will refund or credit the overage amount to you.

If We have not charged the proper amount of Premium, We will let you know the new amount of Premium due from you. We will refund or credit the overage amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If Premium has been paid for any period of time after this Contract has been terminated, We will refund that Premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the Premium paid for such Member for any period after the date of the Member's death to you or your estate.

Premium Refunds

All unearned Premium, less any claims paid, will be refunded.

Program Incentives

We may offer incentives from time to time, at Our discretion, in order to introduce You to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, encouraging You to update Member-related information and encouraging You to enroll automatically to pay Premiums electronically. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.

Medical Policy and Technology Assessment

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

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

Time Limit on Certain Defenses

After three years from the date of issue of this Contract, no misstatements, except fraudulent misstatements, made by you in the application for the Contract will be used to void or cancel the Contract or to deny a claim.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical. Under such circumstances, the Plan and Network Providers will provide health care services provided under this Contract insofar as practical, and according to their best judgment. However, the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Physical Examination

When a claim is pending, We reserve the right to request a Member to be examined by an applicable Provider, at Our expense. This will be requested as often as reasonably required.

Worker's Compensation

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

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness You sustained and You have a right to a Recovery or have received a Recovery.

Subrogation

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

- We have first priority for the full amount of benefits we have paid from any Recovery regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses and injuries.

- You and Your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Contract.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by You, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs You incur without Our prior written consent. We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

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

- You must reimburse Us to the extent of benefits We paid on Your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and Your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon Your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by Us.
- If You fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

The amount We paid on Your behalf is not repaid or otherwise recovered by Us; or

You fail to cooperate.

- In the event that You fail to disclose to Us the amount of Your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of Your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be Your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make You whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to You occurred and all information regarding the parties involved.

- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify Us if You retain an attorney or if a lawsuit is filed on Your behalf.

Right of Recovery and Adjustment

Whenever payment has been made in error, We will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

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

Other Government Programs

The benefits under this Contract shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payer. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

Notice

Any notice given under this Contract shall be in writing. The notices shall be sent to: Anthem Blue Cross and Blue Shield at P.O. Box 37730, Louisville, Kentucky 40233-7730. If We are forwarding You a notice, it will be sent to Your most recent address as it appears in the Plan's system records.

Clerical Error

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of this Contract. This rule applies to any clerical error, regardless of whether it was the fault of the Subscriber or the Plan.

Policies and Procedures

The Plan is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Contract more orderly and efficient.

Waiver

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

Additional Benefits

The Plan has the authority to cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, have, to the fullest extent permitted under applicable law, discretion to determine administration of Your benefits. Our determination shall be binding, subject to any rights of complaint and/or appeal provided under the Contract or under applicable law. This may include, without limitation, determinations of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, whether surgery is cosmetic, and whether charges are consistent with Our Maximum Allowed Amount. However a Member may utilize all applicable complaint and/or appeals procedures specified in the Contract or otherwise required by applicable law. This reservation of discretionary authority shall not be used in such a manner as to deny coverage clearly set forth in the Contract or to arbitrarily construe or abuse the provision of benefits or rights of appeal under the Contract. This reservation of discretionary authority does not prohibit You from seeking judicial review of Our determination after exhausting administrative remedies.

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

Misstatement of Age

If the Premium for this contract is based on Your age and if Your age has been misstated, the benefits will be those the Premium paid would have purchased at the correct age.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Headings

The headings and captions in this Contract are not to be considered a part of this Contract and are inserted only for purposes of convenience.

Value-Added Programs

We may offer health or fitness related programs and products to Our members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics). In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under Your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that You have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under Your Plan. These programs are not guaranteed and could be discontinued at any time. We will give You the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards or retailer coupons, which We encourage You to use for health and wellness related activities or items. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If You have any questions about whether receipt of a gift card or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.)

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. That means giving You access to Our network of health care providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your health care providers about all health care options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your plan.
- Work with Your doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect Us to keep Your personal health information private by following Our privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health plan, and share Your feedback. This includes information on:
    - Our company and services;
    - Our network of health care providers;
    - Your rights and responsibilities;
    - the rules of Your health plan;
    - the way Your health plan works.
- Make a complaint or file an appeal about:
    - Your health plan and any care You receive;
    - any covered service or benefit decision that Your health plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care You may get in the future. This includes asking Your doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health plan rules and policies.
- Choose a Network primary care physician, also called a PCP, if Your health plan requires it.
- Treat all doctors, health care providers and staff with respect.
- Keep all scheduled appointments. Call Your health care provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care providers to make a treatment plan that You all agree on.
- Inform Your health care providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care providers.

- Give Us, Your doctors and other health care providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with Us.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your ID card.

We want to provide high quality benefits and Member Service to Our Members. Benefits and coverage for services given under the Plan are overseen by Your Contract, Member Handbook or Schedule of Cost-Shares and Benefits and not by this Member Rights and Responsibilities statement.

DEFINITIONS

The following terms, defined in this section, are capitalized throughout the Contract so they are easy to identify.

Advance Payments of the Premium Tax Credit (APTC)

The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Alcoholism Treatment Facility

A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

Alternative Care Facility

A non-hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for:

- Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
- Surgery
- Therapy Services or rehabilitation.

Ambulatory Surgical Facility

A facility Provider, with an organized staff of Physicians, that:

- Is licensed as such, where required;
- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

American Indian

The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal

A formal request by You or Your representative for reconsideration of a decision not resolved to Your satisfaction. See the “If You Have a Complaint or an Appeal” section of this Contract.

Authorized Service

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. For more information, see the “Claims Payment” section.

Benefit Year

The term Benefit Year means a calendar year for which a health plan provides coverage for health benefits.

Biosimilar/Biosimilars

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

Brand Name Drug

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

Coinsurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles You owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and You've met Your Deductible, Your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract

The contract between Us and the Subscriber. It includes this Contract, Your Schedule of Cost-Shares and Benefits, Your application, any supplemental application or change form, Your Identification Card, and any endorsements or riders.

Copayment

A fixed amount (for example, $15) You pay for a covered health care service, usually when You receive the service. The amount can vary by the type of covered health care service.

Cost-Share

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

Covered Services

Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Contract is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to You. The incurred date (for determining application of Deductible and other Cost-Share amount) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure

Any of the Medically Necessary non-Experimental/ Investigative human organ and tissue transplants as determined by Us, including necessary acquisition costs and preparatory myeloblative therapy.

Custodial Service or Care

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

- Assistance with walking, bathing, or dressing

- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Day Hospital

A facility that provides day rehabilitation services on an Outpatient basis.

Deductible

The amount You owe for health care services Your health insurance or plan covers before Your health insurance or plan begins to pay. For example, if Your Deductible is $1000, Your plan won't pay anything until You've met Your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost-Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dentally Necessary Orthodontic Care

A service for pediatric members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the Dentally Necessary Orthodontic Care benefit description in the "Dental Services – For Pediatric Members" section for more information.

Dependent

A person of the Subscriber's family who is eligible for coverage under the Contract as described in the "When Membership Changes (Eligibility)" section.

Designated Pharmacy Provider

A Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with Us or a Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Diagnostic Service

A test or procedure performed when You have specific symptoms to detect or to monitor a certain disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the "What Is Covered" section.

Dialysis Facility

A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at Your home. It is not a Hospital.

Domiciliary Care

Care provided in a 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.

Effective Date

The date when a Subscriber's coverage begins under this Contract.

A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified in the "When Membership Changes (Eligibility)" section of this Contract..

Eligible Person

A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency)

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

Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care)

with respect to an Emergency Medical Condition:

- A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
- Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Experimental/Investigative

A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Contract. The Facility must be licensed, accredited, registered or approved by the Joint Commission or The Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by Us.

Family Coverage

Coverage for the Subscriber and eligible Dependents.

Formulary

The term Formulary means a listing of Prescription Drugs that are determined by Anthem to be designated as covered drugs. The list of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Generic Drugs

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

Habilitative Services

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

Home Health Care Agency

A facility, licensed in the state in which it is located, which:

- Provides skilled nursing and other services on a visiting basis in the Member's home; and
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Home Infusion Facility – A facility which provides a combination of:

- Skilled nursing services
- Prescription Drugs
- Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

Hospice Care

A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Hospital

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

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

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

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

Identification Card / ID Card

A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

Inpatient

A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Interchangeable Biologic Product

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

Mail Service

Our Prescription management program which offers You a convenient means of obtaining Maintenance Medications by mail if You take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to Your home.

Maintenance Medication

a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call Customer Service at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

Maintenance Pharmacy

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

Maximum Allowed Amount

The maximum amount that We will pay for Covered Services You receive. For more information, see the "Claims Payments" section.

Medically Necessary or Medical Necessity

Services rendered for the diagnosis or treatment of a condition that are accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medically Necessary services must be cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is not more costly than an alternative service or sequence of services that is medically appropriate.

Medicare

The programs of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member

A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and for whom Premium payment has been made. Members are sometimes called "You" or "Your" in this Contract.

Mental Health and Substance Abuse

A condition, other than autism or pervasive development disorders, that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a Mental Health or Substance Abuse condition.

Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider

A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions for the Network associated with this Contract.

New FDA Approved Drug Product or Technology

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

New FDA Approved Drug Product or Technology does not include:

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

Non-Network Provider

A Provider who has not entered into a contractual agreement with Us for the Network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Network Providers.

Out-of-Pocket Limit

A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. When the Out-of-Pocket Limit is reached, no additional Cost-Shares are required unless otherwise specified in this Contract. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit.

Outpatient

A Member who receives services or supplies while not an Inpatient.

Outpatient Psychiatric Facility

A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

Participating Pharmacy

The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near You, call Member Services at the number on the back of the Member's ID card.

Pharmacy

The term Pharmacy means a place licensed by state law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a prescription from Your Doctor.

Pharmacy and Therapeutics (P&T) Process

The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help You access quality, low cost medicines within Your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include Drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician

A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or ophthalmologist (eye and sight specialist).

Plan (We, Us, Our)

Anthem Health Plans of Kentucky, Inc., dba Anthem Blue Cross and Blue Shield which provides benefits to Members for the Covered Services which are described in this Contract.

Plan Year

The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Precertification

Please see the section "Requesting Approval for Benefits" for details.

Predetermination

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

Premium

The periodic charges due which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug)

The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes insulin, diabetic supplies, and syringes.

Prescription Order

A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Primary Care Physician (“PCP”)

A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization

The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics (P&T) Committee.

Provider

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

Psychiatric Hospital

A facility that, for compensation of its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Health Disorders. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Psychologist

A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Qualified Health Plan or QHP

The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer

The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery

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

Rehabilitative Services

Health care services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Rehabilitation Hospital

A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

Respite Care

Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Retail Health Clinic

A facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.

Self-Administered Injectable Drugs

The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area

The geographical area within which Our Covered Services are available, as approved by state regulatory agencies.

Single Coverage

Coverage for the Subscriber only.

Skilled Nursing Facility

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

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

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

Social Worker

A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.

Specialty Care Physician (SCP)

A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs

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

Stabilize

The provision of medical treatment to You in an emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of Your condition is not likely to result from or during any of the following:

- Your discharge from an emergency department or other care setting where Emergency Care is provided to You;
- Your transfer from an emergency department or other care setting to another facility; or
- Your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State

The term State means each of the 50 States and the District of Columbia.

Subcontractor

The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or Member Services duties on Our behalf.

Subscriber

An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent

The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer

The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect:

1. To file an income tax return for the Benefit Year
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
3. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Telehealth Services

The use of interactive audio, video, or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. A telehealth consultation shall not be reimbursable if it is provided through the use of an audio-only telephone, facsimile machine, or electronic mail.

Therapy Services

Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the “What Is Covered” section.

Tier 1 Drugs

This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier 2 Drugs

This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier 3 Drugs

This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier 4 Drugs

This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Urgent Care Center

A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

NON-NETWORK PROVIDER COVERAGE AMENDMENT

Anthem Blue Cross and Blue Shield

Anthem Health Plans of Kentucky, Inc.

13550 Triton Park Blvd.

Louisville, KY 40223

Individual Anthem On-Exchange/Off-Exchange/MSP Contract

Effective upon issuance, this Amendment revises and becomes a part of the Contract for which you are enrolled through Anthem Blue Cross and Blue Shield. If this Amendment conflicts with any part of the Contract, this Amendment will prevail. Otherwise, all terms and provisions of the Contract shall apply to this Amendment.

Pg. 15 On-Exchange/ Pg. 14 Off-Exchange:

The section titled 'How Your Coverage Works' is amended by adding the following paragraph at the end of the introductory paragraphs, to read as follows:

Services by Providers located outside the Commonwealth of Kentucky will only be Covered Services if:

- The services are for Emergency Care, Urgent Care and ambulance services related to an emergency for transportation to a Hospital; or
- The services are approved in advance by Anthem.

Pg. 16 On-Exchange/ Pg. 15 Off-Exchange:

The following language is added as the first paragraph under the provision 'Non-Network Services':

Services by Providers located outside the Commonwealth of Kentucky will only be Covered Services if:

- The services are for Emergency Care, Urgent Care and ambulance services related to an emergency for transportation to a Hospital; or
- The services are approved in advance by Anthem.

Pg. 19 On-Exchange/ Pg. 18 Off-Exchange:

The following section of the chart is deleted:

Provider Network Status	Responsibility to get Precertification	Comments
Network	Provider	• The Provider must get Precertification when required.
Non-Network/Non-Participating	Member	• Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically

		Necessary.
~~BlueCard® Provider~~	~~Member~~ ~~**(Except for Inpatient Admissions)**~~	• ~~Member must get Precertification when required (call Member Services).~~ • ~~Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.~~ • ~~**BlueCard Provider must obtain precertification for all Inpatient Admissions.**~~
NOTE: For Emergency admissions, You, Your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.		

Pg. 54 On-Exchange/ Pg. 53 Off-Exchange:

Under the section titled 'What Is Not Covered (Exclusions)', the introductory paragraphs are amended as follows:

a.) The following language is being deleted from the contract:

We will not allow benefits for any of the following services, supplies, situations, or related expenses:

Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Ambulance services related to an emergency for transportation to a Hospital.

b.) The following language is being added to the contract:

We will not allow benefits for any of the following services, supplies, situations, or related expenses:

Services by Providers located outside the Commonwealth of Kentucky unless:

- The services are for Emergency Care, Urgent Care and ambulance services related to an Emergency for transportation to a Hospital; or
- The services are approved in advance by Anthem.

Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Ambulance services related to an Emergency for transportation to a Hospital.

Pgs. 72-74 On-Exchange/ Pgs. 71-73 Off-Exchange:

Under the section titled 'Claims Payments', the 'Inter-Plan Arrangements' section is deleted in its entirety from the Contract.

Pg. 74 On-Exchange/ Pg. 73 Off-Exchange:

Under the section titled 'Claims Payments', the 'Network or Non-Network Providers' section is deleted in its entirety and replaced with the following:

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether You receive services from a Network/participating or Non-Network Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for Your Cost-Share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or Cost-Share amounts may vary by the type of Provider You use.

When You receive care outside of the Commonwealth of Kentucky, You may receive it from Providers that contract with the local Blue Cross and/or Blue Shield Plan in that geographic area or from some Providers that don't contract with the local plan. In either case, Anthem covers only limited healthcare services received outside of its Service Area. For example, Emergency or Urgent Care obtained outside the Service Area is always covered. Any other services will not be covered unless authorized by Anthem

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

In some instances, You may only be asked to pay the lower Network Cost-Sharing amount when You use a Non-Network Provider. For example, if You go to a Network/participating Hospital or Provider Facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network Cost-Share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

Anthem Blue Cross and Blue Shield

President

Get help in your language

Curious to know what all this says? We would be too. Here’s the English version: You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ̀ ɓé m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ðá méɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka
Yin nŋ yic ba ye lëk në yök ku bë yi kuny në thöŋ yin jäm ke cin wëu töu kë piiny. Cl rän töŋ dë kc kë lui në nämba dën t në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áajı' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áajı' hodíílnih. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Avei dreptul să obinei aceste informaii i asistenă în limba dvs. în mod gratuit. Pentru asistenă, apelai numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)۔

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish

רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba

O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì èrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.