



Washington County
Public Schools

Lumenos[®] Medical
Plan

Take Control of Your Health

Your Anthem Plan

2015-10-01

Anthem Blue Cross and Blue Shield Lumenos Health Savings Account Plan 3000/6000 Member Booklet

This member booklet fully explains your health care benefits and how *you* can maximize them. Treat it as *you* treat the owner's manual for your car - store it in a convenient place and refer to it whenever *you* have questions about your health care coverage.

Important: This is not an insured benefit plan. The benefits described in this member booklet or any amendments hereto are funded by the employer who is responsible for their payment. *Anthem* provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This health plan is intended to be federally tax qualified and compatible with a qualified health savings account. Approval by the Bureau of Insurance does not guarantee tax qualification and this health plan has not been submitted for approval by the IRS. Please seek the counsel of a tax advisor.

Important phone number

Member Services

800-582-6941

How to obtain language assistance

Anthem is committed to communicating with *our* members about their health plan, regardless of their language. *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 ID card and a representative will be able to assist *you*. Translation of written materials about your benefits can also be requested by contacting Member Services. In the event of a dispute, the provisions of the English version will control.



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 customer service number.)

Hours of operation:

Monday-Friday

8:00 a.m. to 6:00 p.m. ET

Saturday

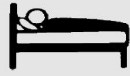
9:00 a.m. to 1:00 p.m. ET

Visit us on-line at:

www.anthem.com



Helpful tip: Look for these icons to identify which services are considered inpatient and which are outpatient. The individual and family icons can be found on the Summary of benefits on page 1, and indicate the deductible and out-of-pocket expense limit amounts for each type of coverage.



Inpatient



Outpatient



Individual



Family

Key words

There are a few key words *you* will see repeated throughout this booklet. *We've* highlighted them here to make the booklet easier to understand. In addition, *we* have included a **Definitions** section on page 75 that lists the various words referenced. A defined word will be italicized each time it is used.

We, us, our, Anthem

Anthem Blue Cross and Blue Shield.

Covered persons

You and enrolled eligible dependents.

Outpatient

When you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

Inpatient

When you are a bed patient in the hospital.

You

The enrolled employee.

Your health plan

Your employer's health care plan through which benefits described in this booklet are available.

Copayment

The fixed dollar amount you pay for some covered services.

Coinsurance

The percentage of the maximum allowed amount you pay for some covered services.

Deductible

The fixed dollar amount of covered services you pay in a plan year before your health plan will pay for any remaining covered services during that plan year.

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Summary of benefits

This chart is an overview of your benefits for *covered services*. They are listed in detail in the **What is covered** section. A list of services that are not covered are listed in the **What is not covered** section.

Please see the “Out-of-network care” paragraph in the **How your program works** section for more information about amounts above the *maximum allowed amount* when services are received from non-participating *providers*.



What will I pay?

This chart shows the most *you* pay for *deductibles* and out-of-pocket expenses for *covered services* in one year of coverage. All covered benefits are subject to the plan year *deductible*; however, in-network wellness services are not subject to the plan year *deductible*.

The out-of-pocket limit generally includes all *deductibles*, *coinsurance*, and *copayments*, if any, *you* pay during a benefit period unless otherwise indicated below. It does not include charges over the *maximum allowed amount* or amounts *you* pay for non-covered services. Please see the **Claims and payments** section for more information.

Note: When during the course of one *visit*, multiple types of service are received where those types of service carry separate benefit *visit* limits (e.g., physical therapy and a spinal manipulation), the one *visit* may count against both limits.

Both in-network and *out-of-network* services accumulate toward the calendar year *deductible*. Amounts applied toward the calendar year *deductible* will also apply to both the in-network and *out-of-network* out-of-pocket expense limits. However, the out-of-pocket expense limits for in-network and *out-of-network* services are separate, and amounts applied to one limit do not apply to the other. *Coinsurance* amounts for in-network services apply only to the in-network limit, and *coinsurance* amounts for *out-of-network* services apply only to the *out-of-network* limit.

	Individual 	Family 	Detail Page Number
Plan year deductible	\$3000	\$6000	47
The most you will pay per plan year for in-network services	\$4000	\$8000	47
The most you will pay per plan year for out-of-network services	\$6000	\$12000	47

If *you* cover only yourself, then *you* must satisfy the individual *deductible* before any *covered services* are paid by the health plan. Once the individual out-of-pocket expense limit has been reached, no additional *coinsurance* will be required of *you* for the remainder of the plan year.

If *you* cover yourself and any other dependents, then the family *deductible* must be satisfied before any *covered services* are paid by the health plan. The family *deductible* may be satisfied and the family out-of-pocket expense

* Services for out-of-network ambulance providers will be subject to the in-network deductible (if any) only.

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	In-network		Out-of-network	Detail
	Copayment	Coinsurance (after plan year deductible)	Coinsurance (after plan year deductible)	Page number
Ambulance Travel (air and water)	\$0	0%	0% *	16
Ambulance Travel (ground)	\$0	0%	0% *	16
Autism services				
Applied behavior analysis	\$0	0%	30%	17
All other services for autism	Copayment/coinsurance determined by service received			17
Dental services	\$0	0%	30%	17
Diabetic equipment and education	\$0	0%	30%	18
Diagnostic tests	\$0	0%	30%	18
for specific conditions or diseases at a doctor's office, emergency room, or outpatient hospital department				
Dialysis treatments				
Facility	\$0	0%	30%	19
Doctor's Office	\$0	0%	30%	19
Doctor visits	\$0	0%	30%	19
on an outpatient basis				
Early intervention services	Copayment/coinsurance determined by service received			20
Covered up to age 3				
Emergency room visits				
Facility services	\$0	0%	30%	20
Professional provider services	\$0	0%	30%	20
Visits to an <i>out-of-network</i> emergency room for <i>emergency services</i> will be covered at in-network benefit levels and apply the in-network cost shares. The <i>facility</i> and <i>provider</i> may balance bill for any amounts in excess of the <i>maximum allowed amount</i> . The <i>out-of-network</i> benefit shown reflects the cost shares for visits to an <i>out-of-network</i> emergency room for services that are not <i>emergency services</i> .				
Home care services	\$0	0%	30%	20
100-visit plan year limit for home health services				
Home private duty nurses services	\$0	0%	**	20
16 hours per member per plan year				
Hospice care services	\$0	0%	30%	21
Hospital services				
Inpatient treatment				
Facility services	\$0	0%	30%	21
Professional provider services	\$0	0%	30%	21
Outpatient treatment				
Facility services	\$0	0%	30%	21
Professional provider services	\$0	0%	30%	21
Infusion services - outpatient services ***				
Facility services	\$0	0%	30%	22
Professional provider services	\$0	0%	30%	22
Home services	\$0	0%	30%	22
Infusion medications				

** Since there is no network required for these services, benefits will be paid as if rendered on an in-network basis.

*** See Hospital services for payment amounts for inpatient therapy.

	In-network		Out-of-network	Detail
	Copayment	Coinsurance (after plan year deductible)	Coinsurance (after plan year deductible)	Page number
Outpatient settings	\$0	0%	30%	22
Home settings	\$0	0%	30%	22
Maternity				
Professional provider services				
Prenatal and postnatal follow-up care	\$0	0%	30%	22
Delivery				
Hospital services for delivery delivery room, anesthesia, nursing care for newborn	\$0	0%	30%	22
Diagnostic tests	\$0	0%	30%	22
Medical equipment (durable), prosthetics, appliances, formulas, supplies, and medications	\$0	0%	30%	23
Mental health or substance use disorder treatment				24
Inpatient treatment (includes residential treatment centers)				
Facility services	\$0	0%	30%	24
Professional provider services	\$0	0%	30%	24
Outpatient facility-based services (includes partial day)	\$0	0%	30%	24
Outpatient office-based treatment	\$0	0%	30%	24
Nutritional counseling for eating disorders	Copayment/coinsurance determined by service received			
Shots (injections) at a doctor's office, emergency room or outpatient hospital department	\$0	0%	30%	25
Skilled nursing facility stays 100-day per stay limit				25
Facility services	\$0	0%	30%	25
Professional provider services	\$0	0%	30%	25
Spinal manipulations and other manual medical interventions 30 – visit plan year limit per member	\$0	0%	30%	26
Surgery				
Inpatient treatment				
Facility services	\$0	0%	30%	26
Professional provider services	\$0	0%	30%	26
Outpatient treatment				
Facility services	\$0	0%	30%	26
Professional provider services	\$0	0%	30%	26
Therapy - outpatient services ***				
Cardiac rehabilitation therapy				
Hospital services	\$0	0%	30%	27
Professional provider services	\$0	0%	30%	27
Chemotherapy				
Hospital services	\$0	0%	30%	27
Professional provider services	\$0	0%	30%	27
Occupational therapy visits				

*** See Hospital services for payment amounts for inpatient therapy.

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	In-network		Out-of-network	Detail
	Copayment	Coinsurance	Coinsurance	Page number
		(after plan year deductible)	(after plan year deductible)	
<hr/>				
30 – visit plan year limit per member (combined with physical therapy visits). Limit does not apply to autism services.				
<i>Hospital services</i>	\$0	0%	30%	28
<i>Professional provider services</i>	\$0	0%	30%	28
<hr/>				
Physical therapy visits				
30 – visit plan year limit per member (combined with occupational therapy visits). Limit does not apply to autism services.				
<i>Hospital services</i>	\$0	0%	30%	28
<i>Professional provider services</i>	\$0	0%	30%	28
<hr/>				
Radiation therapy				
<i>Hospital services</i>	\$0	0%	30%	28
<i>Professional provider services</i>	\$0	0%	30%	28
<hr/>				
Respiratory therapy				
<i>Hospital services</i>	\$0	0%	30%	28
<i>Professional provider services</i>	\$0	0%	30%	28
<hr/>				
Speech therapy visits				
30 – visit plan year limit per member. Limit does not apply to autism services.				
<i>Hospital services</i>	\$0	0%	30%	28
<i>Professional provider services</i>	\$0	0%	30%	28
<hr/>				
Vision correction	\$0	0%	30%	28
after surgery or accident				
<hr/>				
Wellness services	\$0	0%	30%	28
for children and adults				
The plan year deductible does not apply to wellness services received in network; however, if wellness services are received from out-of-network providers, the services will be subject to the plan year deductible. Screenings received for diagnostic purposes (as billed by the in or out-of-network provider or facility) are not considered to be wellness services, and therefore will also be subject to the plan year deductible.				
<hr/>				
Wigs	\$0	0%	30%	30
Limited to one wig per member per plan year				

	Copayment	Coinsurance	Detail Page number
Prescription drug retail pharmacy and home delivery (mail order) benefits			30

All *prescription drug* expenses are subject to the plan year *deductible* shown on page 1. Once the plan year *deductible* has been satisfied, the following benefits apply:

Each *prescription drug* will be subject to a cost share (e.g., *copayment/coinsurance*) as described below. If your prescription order includes more than one *prescription drug*, a separate cost share will apply to each covered *drug*.

Day/supply limitations

Prescription drugs will be subject to various day supply and quantity limits. Certain *prescription drugs* may have a lower day-supply limit than the amount shown below due to other plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

Retail pharmacy (in-network and out-of-network) 30 days

Home delivery (mail order) pharmacy 90 days

Specialty pharmacy (in-network and out-of-network) 30 days*
*See additional information in the "Specialty drug copayments/coinsurance" section below.

Prescription drug copayment / coinsurance for **Preventive Rx** prescription drugs as listed on the Expanded list No copayment / deductible / coinsurance

Retail pharmacy copayments/coinsurance

	Copayment	Coinsurance
Tier 1 prescription drugs	\$10	0%
Tier 2 prescription drugs	\$30	0%
Tier 3 prescription drugs	\$50	0%
Tier 4 prescription drugs	\$0	20% to a maximum of \$200 per prescription drug

Home delivery pharmacy copayments/coinsurance

	Copayment	Coinsurance
Tier 1 prescription drugs	\$25	0%
Tier 2 prescription drugs	\$75	0%
Tier 3 prescription drugs	\$125	0%
Tier 4 prescription drugs	\$0	20% to a maximum of \$400 per prescription drug

Specialty drug copayments/coinsurance

Please note that certain *specialty drugs* are only available from a *specialty pharmacy* and you will not be able to get them at a retail *pharmacy* or through the home delivery (mail order) *pharmacy*. Please see "Specialty pharmacy" in the section "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" for further details. When you get *specialty drugs* from a *specialty pharmacy*, you will have to pay the same *copayments/coinsurance* you pay for a 30-day supply at a retail *pharmacy*.

Note: Certain diabetic and asthmatic supplies are covered subject to applicable *prescription drug copayments* when you get them from an in-network *pharmacy*. These supplies are covered as medical supplies and durable medical equipment if you get them from an out-of-network *pharmacy*. Diabetic test strips are covered subject to applicable *prescription drug copayment/coinsurance*.

How your health plan works

Your health plan provides a wide range of health care services within a special network of health care *providers* and *facilities*. You will receive benefits based on where you receive health care services and the limits stated in the **Summary of benefits** (see page 1) and related exclusions. *Your health plan* is a self-funded employee welfare benefit plan sponsored by your employer. The cost of your coverage, which includes the plan benefits and administrative expenses, is borne by your employer. Employees may contribute to the cost through payroll deduction. Your employer has entered into an administrative services contract with *Anthem* to carry out certain functions with respect to claims operation.

Carry your ID card

Your Anthem Blue Cross and Blue Shield ID card identifies you as a *covered person* and contains important health care coverage information. When you show your ID card to your doctor, hospital, pharmacist, or other health care *provider*, they will file your claims for you in most cases. Carrying your card at all times will ensure you always have this coverage information with you when you need it.

Covered providers and facilities

Your health plan covers certain care administered by *providers* and *facilities*. To ensure benefits, *providers* and *facilities* must be licensed in the state where they operate to perform the service you receive and the service must be covered by *your health plan*. Certain services are covered by the plan and rendered by other covered medical suppliers, such as suppliers of *medical equipment (durable)*, private duty nursing services, *prescription drugs*, ambulance services, etc.

A *provider* may delegate to his employee the responsibility for performing a *covered service*. *Your health plan* will cover this care if we determine that a bona fide employer-employee relationship exists, based on information given by the *provider*. Under these circumstances:

- both the *provider* and the delegated employee must be licensed/certified to render the service;
- the service must be performed under the direct supervision of the *provider* since the *provider* is primarily responsible for the patient's care; and
- the *provider* who is directly supervising the service must bill for the service.

Because the service of the delegated employee is a substitute for the *provider's* service, *your health plan* will not pay a supervisory or other fee for the same service performed by both the *provider* and his delegated employee.

Choose a health care provider

In Virginia

You have the freedom to receive care from any *provider* or *facility*. However, you receive the highest level of benefits when you receive care from *providers* and *facilities* within the *KeyCare PPO Network*. Care received from *KeyCare PPO Network providers* and *facilities* is considered in-network care. Your policy provides coverage for certain services that do not have *providers* within *our* networks. These services would be considered in-network services. An example is private duty nursing services.

Note: You may call Member Services for information regarding the qualifications of providers in the KeyCare PPO Network. Qualifications include: medical school attended, residency completed, and board certification status.

Out-of-area services

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain health care services outside of *our* service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between *us* and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside *our* service area, you will obtain care from health care *providers* that have a contractual agreement (i.e., are “participating *providers*”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating health care *providers*. *Our* payment practices in both instances are described below.

BlueCard® Program

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

Whenever you access covered health care services outside *our* service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services, is calculated based on the lower of:

- the billed covered charges for your *covered services*; or
- the negotiated price that the Host Blue makes available to *us*.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted

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above. However, such adjustments will not affect the price *we* use for your claim because they will not be applied retroactively to claims already paid.

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

Non-participating health care providers outside our service area

1. Member Liability Calculation

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

2. Exceptions

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

Note: In the event that you travel outside of Virginia and receive services in a state with more than one Blue plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider's service(s) will be considered out-of-network care, and you may be billed the difference between the charge and the maximum allowed amount. You may call Member Services or go to www.anthem.com for information regarding such arrangements.

You can also access doctors and hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before *you* travel outside the United States, check with your group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your up-to-date identification card.
- In an emergency, go straight to the nearest hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a doctor visit or hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- *You* need to find a doctor or hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a doctor visit or Hospital stay, if needed.
- *You* need inpatient care. After calling the Service Center, *you* must also call *us* to get approval for benefits at the phone number on your identification card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- Participating BlueCard Worldwide Hospitals. In most cases, when *you* make arrangements for a hospital stay through BlueCard Worldwide, *you* should not need to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-covered services, deductible, copayments and coinsurance) *you* normally pay. The hospital should send in your claim for *you*.
- Doctors and/or non-participating hospitals. *You* will need to pay upfront for outpatient services, care received from a doctor, and inpatient care not arranged through the BlueCard Worldwide Service Center. Then *you* can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The hospital will file your claim if the BlueCard Worldwide Service Center arranged your hospital stay. *You* will need to pay the Hospital for the out-of-pocket costs *you* normally pay.
- *You* must file the claim for outpatient and doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center. *You* will need to pay the Provider and subsequently send an international claim form with the original bills to *us*.

Claim Forms

You can get international claim forms from *us*, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

How to find a provider in the network

There are four ways *you* can find out if a *provider* or *facility* is in your network:

- Refer to *your health plan's* directory of network *providers* at www.anthem.com, which lists doctors and health care *facilities* that participate in *your health plan's* network, as well as information about the standards of care in area hospitals.
- Call *Anthem's* Member Services to request a list of doctors and health care *facilities* that participate with *Anthem*, based on specialty and geographic area.
- Check with your doctor or health care *facility*.
- Ask your group administrator.

All network *providers* have a process in place to help *you* access urgent medical care 24 hours a day, 7 days a week. If *you* require urgent medical care after your doctor's normal business hours call his/her office and *you* will be directed to needed care.

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Please note that not all in-network providers offer all services. For example, some hospital-based labs are not part of our Reference Lab Network. In those cases, you will have to go to a lab in our Reference Lab Network to get in-network benefits. Please call Member Services before you get services for more information.

Out-of-network care

Out-of-network care is covered at a lower level of benefits than in-network care. After you satisfy a plan year *deductible* (if any), you are responsible for your *coinsurance*, a percentage of the *maximum allowed amount* as stated in the Summary of benefits (see page 1). If the *out-of-network* ambulance, *provider* or *facility* participates in any *Anthem* network or other Blue Cross Blue Shield company's network, they will accept the *maximum allowed amount* as payment in full for their services. However, ambulances, *providers* and *facilities* that do not participate in any *Anthem* or Blue Cross Blue Shield company's network may bill you for the difference between their charge and the *maximum allowed amount*.

The advance approval process

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

Your *health plan* will make coverage decisions on services requiring advance approval (for example, *home care services*, etc.), within 15 days from the receipt of the request. Your *health plan* may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, your *health plan* will make its decision within 2 working days of its receipt of all necessary clinical information needed to process the advance approval request.

For *urgent care claims*, coverage decisions will be completed and we will respond to you and your *provider* as soon as possible taking into account your medical condition, but not later than 72 hours from receipt of the request. If insufficient information is submitted in order to review the claim, we will ask you or your *provider* for the information needed within 24 hours of the receipt of your request, and make our decision within 48 hours of receiving the information. If the requested information is not received within 48 hours of our request, we will make our decision within 96 hours from the date of our request.

Once your *health plan* has made a coverage decision on services requiring advance approval, you will receive written notification of the coverage decision. In the event of an *adverse benefit determination*, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of your *health plan's* appeal procedures and applicable time limits;

- in the case of an *urgent care claim*, a description of the expedited appeal and expedited review process applicable to such claims; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist *you* with the internal or external appeals process.

If all or part of a pre-service or *urgent care claim* was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that *your health plan* relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, *you* are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

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

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

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

You may determine whether a *provider* is participating in certain programs by checking *your health plan's* on-line *provider* directory or contacting customer service number on the back of your ID card.

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

Approvals of care involving an ongoing course of treatment

Network providers must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If *you* are receiving care from a non-network *provider* and need to receive an extension of a previously approved course of treatment, *you* will be required to ask for the extension. *You* should request the extension at least 24 hours prior to the end of the authorized time frame to avoid disruption of care or services. *We* will notify *you* of our coverage decision within 24 hours of your request.

If *we* make a determination to reduce or terminate benefits for all or any part of a previously approved course of treatment prior to its conclusion, this will be considered an adverse benefit determination. If the reduction or termination was not a result of a health plan amendment or health plan termination, *we* will notify *you* in advance of the reduction or termination in sufficient time for *you* to file an internal appeal prior to the reduction or termination.

In an emergency or if specialty care is not reasonably available in the network

If *you* have an emergency medical condition, go to the nearest appropriate provider or medical facility. Visits to an out-of-network emergency room for emergency services will be covered at in-network benefit levels and apply the in-network cost shares.

If specialty care is required and it's not available from a provider within the network, your network provider can call *Anthem* in advance of your receiving care to have the *out-of-network* services authorized for the highest level of benefits.

Hospital Admission Review

All hospital *stays* or skilled nursing home *stays* should be approved before each admission. The exception to this is maternity admissions as specified in the maternity section of this booklet. If *you* are admitted to the hospital as a result of an *emergency medical condition*, your hospital *stay* should be reviewed by *Anthem* within 48 hours of admission. The emergency room doctor, a relative, or a friend can call for Hospital Admission Review. Network *providers* and *facilities* handle Hospital Admission Review for *you*. *You* must initiate the Hospital Admission Review process for *out-of-network* services. If *you* fail to obtain approval for an *inpatient stay*, and the *stay* is later determined not to be *medically necessary*, *you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient*. Strict adherence to this procedure may not be required for services that arise over the weekend.

Before *you* are admitted to the hospital for medical care or surgery, *you* or someone *you* authorize must call the Member Services telephone number located on your identification card. If your *provider* is calling on your behalf, the telephone number for *providers* is 804-342-0010 in Richmond or toll-free 800-533-1120. *You* should have the following information available:

- your Anthem Blue Cross and Blue Shield identification number (shown on your ID card);
- your doctor's name and phone number;
- the date you plan to enter the hospital and length of stay; and
- the reason for hospitalization.

Your health plan will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 15-day period.

In cases where the hospital admission is an *urgent care claim*, a coverage decision will be completed within 24 hours. Your physician will be notified verbally of the coverage decision within this time frame.

Once a coverage decision has been made regarding your hospital admission, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination*, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;

- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *your health plan's* appeal procedures and applicable time limits;
- in the case of an *urgent care claim*, a description of the expedited review process applicable to such claims; and
- the availability of, and contract information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist *you* with the internal or external appeals process.

If all or part of a hospital admission was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that *your health plan* relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, *you* are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

The length of *stay* for maternity admissions is determined according to the Newborn's and Mother's Health Protection Act. This federal law allows for 48 hours for vaginal delivery or 96 hours for caesarian section. Admissions for maternity care do not, initially, require Hospital Admission Review. However, if complications develop and additional days are necessary, Hospital Admission Review is required. We request that your doctor contact *Anthem* to establish eligibility and waiting periods.

Admissions to hospitals located outside of Virginia

If *you* are admitted to a hospital outside of Virginia, *you* or someone on your behalf must initiate the Hospital Admission Review process. This applies in all cases, whether *you* live, work, or travel outside of Virginia. If approval is not obtained for an *inpatient stay* and the *stay* is later determined by *Anthem* not to be *medically necessary*, *you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient*.

Health plan individual case management

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

Our Case Management programs are confidential and voluntary and are made available at no extra cost to *you*. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any *covered services* *you* are receiving.

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

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

In certain cases of severe or chronic illness or injury, *we* may provide benefits for alternate care that is not listed as a *covered service* through our Case Management program. *We* may also extend *covered services* beyond the benefit maximums of this plan. *We* will make our decision 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 a case, *we* will notify *you* or your authorized representative in writing.

Also, from time to time your health plan may offer a *covered person* and/or their *provider* or *facility* information and resources related to disease management and wellness initiatives. These services may be in conjunction with the *covered person's* medical condition or with therapies that the *covered person* receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

Voluntary clinical quality programs

We may offer additional opportunities to assist *you* in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) within a specific timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage *you* to get certain care when *you* need it and are separate from *covered services* under 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. Under other clinical quality programs, *you* may receive a home test kit that allows *you* to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. *You* may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee), but will not need to pay for the home test kit. (If *you* receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to *you*. For additional guidance, please consult your tax advisor.)

Voluntary wellness incentive programs

We may offer health or fitness related program options for purchase by your group to help *you* achieve your best health. These programs are not *covered services* under your plan, but are separate components, which are not guaranteed under this plan and could be discontinued at any time. If your group has selected one of these options to make available to all employees, *you* may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a group may select, *you* may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If *you* think *you* might be unable to meet the standard, *you*

might qualify for an opportunity to earn the same reward by different means. You may contact us at the member service number on your ID card and we will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

If you changed plans within the year

Your health plan may include plan year limitations on deductibles, out-of-pocket expenses, or benefits. These limitations may be affected by a change of health plan coverage during the plan year.

- If you change from one employer's health plan to another employer's health plan during the plan year, new limitations will apply as of your effective date of coverage under the new employer's health plan. Amounts that may have accumulated toward similar limitations under your former employer's health plan will not count toward the limitations under your new employer's health plan.
- If you do not change employers, but move from Anthem HealthKeepers coverage (issued by an Anthem-affiliated HMO) to Anthem coverage during the plan year, new limitations will apply as of the effective date of your Anthem coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket requirements under the Anthem HealthKeepers will not count toward the limitations under the Anthem coverage.
- If you do not change employers, but move from non-Anthem coverage (issued by any other company) to Anthem coverage during the plan year, new limitations will apply as of the effective date of your Anthem coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket requirements under the non-Anthem coverage will not count toward the limitations under the Anthem coverage.

If you do not change employers, but move from one Anthem benefit plan or option to another Anthem benefit plan or option during the plan year, any amounts that had accumulated toward plan year limitations before the change will not count toward similar limitations under the new Anthem benefit plan or option for the remainder of the plan year.

What is covered

All benefits are subject to the terms, conditions, definitions, limitations, and exclusions described in this booklet. Only *medically necessary covered services* will be provided by Anthem. If a service is not considered *medically necessary*, you will be responsible for the charges. Additionally, we will only pay the charges incurred by you when you are actually eligible for the *covered services* received (for example, the premium has been paid by you or on your behalf).

See the **Summary of benefits** on the first page for payment levels and limits for the *covered services*. For details of the specific coverage provided as well as what is not covered, use the page number references on the summary. All of the following services, except as noted, must be rendered by covered *facilities* or *providers*.

Ambulance travel



Medically necessary ambulance services are a *covered service* when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by emergency medical technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical emergency to a hospital;
 - Between hospitals, including when we require you to move from an *out-of-network* hospital to an in-network hospital;
 - Between a hospital and a *skilled nursing facility* or other approved facility.
- For air or water ambulance, you are taken:
 - From the scene of an accident or medical emergency to a hospital;
 - Between hospitals, including when we require you to move from an *out-of-network* hospital to an in-network hospital
 - Between a hospital and an approved *facility*.

Ambulance services are subject to medical necessity reviews by us. When using an air ambulance for non-emergency transport, we reserve the right to select the air ambulance provider. If you do not use the air ambulance provider we select, the *out-of-network* provider may bill you for any charges that exceed the plan's *maximum allowed amount*.

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

Benefits also include *medically necessary* treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a *facility*.

Important Notes on Air Ambulance Benefits

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

Air ambulance will not be covered if *you* are taken to a hospital that is not an acute care hospital (such as a *skilled nursing facility*), or if *you* are taken to a physician's office or your home.

Hospital to Hospital Transport

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

Autism services



Your health plan covers certain treatments associated with autism spectrum disorder (ASD) for dependents from age two through age six. Coverage for ASD includes but is not limited to the following:

- diagnosis of autism spectrum disorder;
- treatment of autism spectrum disorder;
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

Treatment for ASD includes *applied behavior analysis* when provided or supervised by a board certified behavior analyst, licensed by the Board of Medicine, and billed by such behavior analyst, and the prescribing practitioner is independent of the provider of the *applied behavior analysis*.

Dental services (All Members/All Ages)

Preparing the mouth for medical treatments

Your plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. *Covered services* include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of accidental injury

Benefits are also available for dental work needed to treat injuries to the jaw, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an accidental injury under this plan, unless the chewing or biting results from a medical or mental condition.

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Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.

Hospitalization for anesthesia and dental procedures

Your plan includes coverage of general anesthesia and hospitalization services for children under the age of 5, *covered persons* who are severely disabled and *covered persons* who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the *covered person's* treating physician that such services are required to effectively and safely provide dental care.

Note: We provide coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by us, are not *covered services*.

Diabetic equipment and education



Your *health plan* covers medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles and syringes when purchased from a pharmacy; and
- *outpatient* self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

Diabetic education may be received from pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

Screenings for gestational diabetes are covered under Wellness services.

Diagnostic tests



Your benefits include coverage for the following procedures when ordered by your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms:

- radiology (including mammograms), ultrasound or nuclear medicine;
- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs; and
- advanced diagnostic imaging services.

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital *stay* is covered under *your health plan* only when:

- your medical condition requires that medical skills be constantly available;
- your medical condition requires that medical supervision by your doctor is constantly available; or
- diagnostic services and equipment are available only as an *inpatient*.

Outpatient diagnostic imaging tools can be the key to identifying underlying health problems, but unnecessary imaging may contribute to patient safety issues: increased radiation exposure and false positive findings that may result in additional unnecessary testing and potential surgical procedures. To help ensure that *you* are receiving services that are safe and appropriate, *we* have made available a health services review process for physicians ordering these services. Health services review is a process

performed in advance of receiving an outpatient advanced diagnostic imaging service. The purpose is to review for safety, appropriateness, and medical necessity, and to determine whether the service meets coverage guidelines. If your doctor orders one of the following tests for you, we suggest that you ask your doctor to initiate a health services review by contacting *Anthem*:

- magnetic resonance angiography (MRA);
- magnetic resonance imaging (MRI);
- magnetic resonance spectroscopy (MRS);
- computed tomographic angiography (CTA);
- positron emission tomography (PET) scans;
- computed tomography (CT) scans;
- single photon emission computed tomography (SPECT) scans; and
- nuclear cardiology.

Note: While there is no penalty if the health services review is not performed in advance of receiving the service, the advantage of the front-end review is that you and your doctor know beforehand whether the service is appropriate, medically necessary, and meets coverage guidelines. If advance approval is not obtained and the service is later determined not to be *medically necessary*, you may have to pay for the service.

Medical supplies and other services that may be required and provided in conjunction with a diagnostic test are not considered part of the diagnostic test. Therefore, if a *facility* or *provider* bills a separate charge for such services or supplies, benefits for such services or supplies will be provided as described in the **Summary of benefits** for such services and supplies and not as part of the diagnostic test.

Dialysis



Your *health plan* covers dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

Doctor visits and services



Your *health plan* covers:

- visits to a doctor's office or your doctor's visits to your home;
- visits to an urgent care center;
- visits to a hospital *outpatient* department or emergency room;
- visits for shots needed for treatment (for example, allergy shots); and
- interactive *telemedicine* services.

Early intervention services



Your health plan covers early intervention services for covered dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services (“the Department”) as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be *medically necessary* by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not *medically necessary*.

Emergency room care



Your health plan covers emergency room visits, services, and supplies. If you are admitted to the hospital from the emergency room, the hospital stays must be reviewed by Anthem within 48 hours of admission. The emergency room doctor, a relative, or a friend can call Anthem for Hospital Admission Review (see the **How your program works** section) in an emergency.

Home care services



Your health plan covers treatment provided in your home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat your condition. To ensure benefits, your doctor must provide a description of the treatment you will receive at home. Your coverage includes the following home health services:

- visits by a licensed health care professional, including a nurse, therapist, or home health aide; and
- physical, speech, and occupational therapy (services provided as part of home health are not subject to separate visit limits for therapy services).

These services are only covered when your condition generally confines you to your home except for brief absences.

Home private duty nurse's services



Your health plan covers the cost of medically skilled services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home when the nurse is not a relative or member of your family. Your doctor must certify to us that private duty nursing services are *medically necessary* for your condition, and not merely custodial in nature.

Hospice care services



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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term *inpatient* hospital care when needed in periods of crisis or as respite care. Coverage includes short-term *inpatient* care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the *covered person* in order to provide the *covered person's* primary caregiver a temporary break from caregiving responsibilities.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the member's death. Bereavement services are available to surviving members of the immediate family for one year after the member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

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

Benefits for *covered services* beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a member in hospice. These additional *covered services* will be covered under other parts of this plan.

Hospital services



Your health plan covers the hospital and doctors' services when you are treated on an outpatient basis, or when *you* are an *inpatient* because of illness, injury, or pregnancy. (See "Maternity" later in this section for an additional discussion of pregnancy benefits.) *Your health plan* covers *medically necessary* care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services.

In addition to your semi-private room, general nursing services and meals, *your health plan* covers the *maximum allowed amount* for *medically necessary* services and supplies furnished by the *hospital* when prescribed by your doctor or *provider*.

The hospital must meet the American Hospital Association's standards for registration as a hospital. Remember that your share of the cost of *covered services* will change if you use a doctor, *facility*, or other health care provider that is outside your network.

While you are an *inpatient* in the hospital, your health plan covers the medically necessary services rendered by doctors and other covered providers.

Note: All non-emergency inpatient hospital stays must be approved in advance, except hospital stays for vaginal or cesarean deliveries without complications.

Private room

Your *health plan* will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your *inpatient* benefits would cover the hospital's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your *copayment* and *coinsurance* (if any).

Infusion services



Your *health plan* covers infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

Note: Infusion services may be received at multiple sites of service, including facilities, *professional provider offices*, ambulatory infusion centers and from home infusion *providers*. Benefits may vary by place of service, and where you choose to receive covered services may result in a difference in your *copayment* and/or *coinsurance*. Please see the Infusion services section on the **Summary of benefits** for a description of the benefits by place of service.

Maternity



Prenatal and newborn care

If you (or your covered dependent) become pregnant, your *health plan* provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered by your *health plan*.

Note: See “If your family changes” in the **Changing your coverage** section for details on when and how to enroll a newborn.

Your benefits include:

- use of the delivery room and care for normal deliveries;
- home setting covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother's normal hospital stay;

- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- initial examination of a newborn and circumcision of a covered male dependent;
- services for interruption of pregnancy; and
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

Future Moms

You (or your covered dependent) are eligible to participate in Future Moms. This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A Future Moms consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery. As soon as pregnancy is confirmed, sign up for the program by calling 800-828-5891. *You* will receive:

- a kit containing educational material on how to get proper prenatal care and identify signs of premature labor;
- a risk appraisal to identify signs of premature labor; and
- after delivery, a birth kit and child care book.

Medical equipment (durable)



Your health plan will cover the rental (or purchase if that would be less expensive) of *medical equipment (durable)* when prescribed by your doctor. Also covered are maintenance and necessary repairs of *medical equipment (durable)* except when damage is due to neglect.

Coverage includes the following types of equipment:

- nebulizers;
- hospital type beds;
- wheelchairs;
- traction equipment;
- walkers; and
- crutches.

Medical devices, prosthetics, and appliances



Your health plan covers the cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for *activities of daily living*:

- prosthetic devices and components;
- orthopedic braces;
- leg braces, including attached or built-up shoes attached to the leg brace;
- molded, therapeutic shoes for diabetics with peripheral vascular disease;
- arm braces, back braces, and neck braces;
- head halters;
- catheters and related supplies;
- orthotics, other than foot orthotics; and
- splints.

A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot, or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device.



Medical formulas

Your *health plan* covers special medical formulas which are the primary source of nutrition for *covered persons* with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Medical supplies and medications

Medical supplies are covered under your *health plan* if they are prescribed by a covered *provider*. Examples of medical supplies include:

- hypodermic needles and syringes;
- oxygen and equipment (respirators) for its administration;
- prescription medications provided by your doctor; and
- prescription medications infused through IV therapy in the physician's office or *outpatient facilities*.

Certain medical supplies may be covered under the *prescription drug* card feature of your *health plan* when purchased by you and supplied directly to you by a *pharmacy*. If so, these supplies will be listed and covered under "Prescription drug benefit at a retail or home delivery (mail order) pharmacy."

Injectable medications

Your coverage includes benefits for self-administered injectable medications obtained through a retail pharmacy or administered by a *participating provider*. Please see "Prescription drugs administered by a medical provider" and "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" at the end of **What is covered** for detailed information.

Mental health or substance use disorder treatment

Accessing your mental health services and substance use disorder services (treatment of alcohol or drug dependency) is easy. In fact, you have a dedicated department available to you simply by calling 800-991-6045. All members can select any mental health and substance use disorder *provider* listed in your *provider* directory. Or if you are unsure of which *provider* to see, call 800-991-6045 and the representative will be able to match you with a *provider* who seems best suited to meet your needs.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, electroconvulsive therapy, detoxification, and rehabilitation.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs. Covered services include individual psychotherapy, group psychotherapy, psychological testing and

medication management visits (visits to your physician to make sure that the medication you are taking for a mental health or substance use disorder is working and the dosage is right for you).

- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center or intermediate care Facility. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, and education.

You can get covered services from the following providers:

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

Shots (Injections)



Your *health plan* covers therapeutic injections (shots) that a *provider* gives to treat illness (e.g., allergy shots) or pregnancy-related conditions. Also included is allergy serum for allergy shots. In addition, you have coverage for immunizations and self-administered injections.

Some injections may be administered by pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

Skilled nursing facility stays



Your coverage includes benefits for skilled nursing home stays. Coverage for your stay requires prior approval. Your doctor must submit a plan of treatment that describes the type of care you need. The following items and services will be provided to you as an inpatient in a skilled nursing bed of a *skilled nursing facility*:

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.

Your *health plan* will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your *inpatient* benefits would cover the skilled nursing facility's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your *copayment and coinsurance* (if any).

Custodial or residential care in a *skilled nursing facility* or any other facility is not covered except as rendered as part of hospice care.

Spinal manipulation and other manual medical interventions



Your *health plan* covers spinal manipulation services (manual medical interventions) and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations such as massage and myofascial release.

Surgery

General surgery



Surgery charges are covered when treatment is received at an *inpatient*, outpatient or ambulatory surgery facility, or doctor's office. Your *health plan* will not pay separately for pre- and post-operative services.

Reconstructive breast surgery and mastectomy

Mastectomy, or the surgical removal of all or part of the breast, is a covered service. Also covered are:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the *covered person*.

Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts is also covered.

Oral surgery

Important Note: Although this plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is *medically necessary* to attain functional capacity of the affected part.
- Oral/surgical correction of accidental injuries as indicated in the “Dental Services (All Members/All Ages)” section.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Organ and tissue transplants, transfusions

Your *health plan* covers organ and tissue transplants and transfusions. When a covered human organ or tissue transplant is provided from a living donor to a *covered person*, both the recipient and the donor may receive the benefits of the health plan.

Note: Certain organ or tissue transplants are considered *experimental/investigative* or not *medically necessary*. You may wish to contact Member Services or have your *provider* initiate the pre-authorization process to determine if a specific transplant will be covered.

Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of *experimental/investigative* services.

To maximize your benefits, *you* 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. Your evaluation and work-up services must be provided by a network transplant provider to receive the maximum benefits.

Therapy



Your *health plan* covers the following therapies when the treatment is *medically necessary* for your condition and provided by a licensed therapist:

Cardiac rehabilitation therapy

Your *health plan* includes benefits for cardiac rehabilitation which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

Chemotherapy

Your *health plan* covers the treatment of disease by chemical or biological antineoplastic agents.

Occupational therapy

Your *health plan* covers occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

Physical therapy

Your health plan covers physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema.

Radiation therapy

Your health plan covers radiation therapy including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

Respiratory therapy

Your health plan covers respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

Speech therapy

Your health plan covers speech therapy, which is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.

Vision correction after surgery or accident



Your health plan covers the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
 - contact lenses are used for the treatment of infantile glaucoma;
 - corneal or scleral lenses are prescribed in connection with keratoconus;
 - scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
 - corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism

Wellness services



Your health plan covers preventive care services for children, adolescents and adults. Preventive care services generally include check-up visits, developmental assessment and guidance, screening tests,

intervention counseling/education services, immunizations and other services to prevent the development of disease, or allow the detection of medical conditions in advance.

Services are covered as preventive care for children, adolescents and adults with no current symptoms or prior history of the medical condition associated with the screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition, but instead benefits will be considered under the diagnostic services benefit.

Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and your *provider* performs additional necessary *covered services*, these services will generally be covered as diagnostic and/or surgical services and not as preventive care services. Also, covered screenings that *you* undergo because *you* have a personal or family history of a particular condition are not generally covered as preventive care services. *Deductibles*, *copayments* and *coinsurance* amounts applicable to diagnostic and/or surgical services may be different from those applicable to preventive care services. Please see the Diagnostic tests and Surgery sections on the **Summary of benefits** for more information.

The preventive care services in this section meet the requirements outlined under federal and state law. Preventive care services covered by your *health plan* that meet these requirements are not subject to cost shares (for example, *deductible*, *copayment*, and/or *coinsurance* amounts) when services are received from in-network *providers*. That means *Anthem* pays 100% of the *maximum allowed amount*. Cost shares will apply when services are received from *out-of-network providers*. These services fall under four broad categories as shown below:

1. services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
 - breast cancer;
 - cervical cancer;
 - colorectal cancer;
 - high blood pressure;
 - type 2 diabetes mellitus;
 - cholesterol;
 - child and adult obesity.
2. immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - women’s contraceptives including all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and counseling. Contraceptive coverage includes generic and single-source brand drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Standard multi-source brand drugs will be covered under the prescription drug benefit;

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- breastfeeding support, supplies, and counseling. Standard benefits for breast pumps are limited to one pump per pregnancy;
- gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes;
- testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of pap smear results;
- annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women;
- screening and counseling for interpersonal and domestic violence;
- well woman *visits*.

5. counseling services related to general nutrition, and to smoking and tobacco use cessation.

You may call Member Services at 800-582-6941 for additional information about these services. You may also visit the federal government websites:

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

In addition to the Federal requirements above, preventive coverage also includes the following *covered services* at intervals no less frequent than required by state law:

- Routine screening mammograms;
- Routine annual Pap tests including coverage for testing performed by any FDA-approved gynecologic cytology screening technologies;
- Routine annual prostate specific antigen testing and digital rectal exams for male enrollees age 40 and older.

Wigs



Your *health plan* covers a wig when needed to replace scalp hair following an illness or injury. Benefits are limited to one wig per member per plan year and are available despite the exclusion in the plan of benefits for, or related to, cosmetic surgery or procedures.

Prescription drugs administered by a medical provider



Your plan covers *prescription drugs* when they are administered to *you* as part of a doctor's visit, home care visit, or at an *outpatient* facility. This includes *drugs* for infusion therapy, chemotherapy, *specialty drugs*, blood products, and office-based injectables that must be administered by a *provider*. This section applies when *your provider* orders the drug and administers it to *you*.

Benefits for *drugs* that *you* inject or get at a *pharmacy* (i.e., self-administered injectable *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 that follows.

Note: When *prescription drugs* are covered under this benefit, they will not also be covered under the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" benefit. Also, if *prescription drugs* are covered under the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" benefit, they will not be covered under this benefit.

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 *medically necessary*. We may also set quantity and/or age limits for specific *prescription drugs* or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or *pharmacy and therapeutics process*.

Prior authorization

Prior authorization may be needed for certain *prescription drugs* to make sure proper use and guidelines for *prescription drug* coverage are followed. We will contact your provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your provider.

If prior authorization is denied you have the right to file a grievance as outlined in the **Important information** section of this booklet.

For a list of *drugs* that need prior authorization, 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 *drug* or related item on the list does not promise coverage under your plan. Your provider may check with us to verify *drug* coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which *brand* or *generic drugs* are covered under the Plan.

Step therapy

Step therapy is a process in which you may need to use one type of drug before we will cover another. We check certain *prescription drugs* to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective *prescription drugs*. If a doctor decides that a certain drug is needed, prior authorization will apply.

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. We have a therapeutic drug substitutes list, which we review and update from time to time. 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 in a medical setting (e.g., doctor's office, 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

As described in the “Prescription drugs administered by a medical provider” section, *prescription drug* benefits may depend on reviews to decide when *drugs* should be covered. These reviews may include prior authorization, step therapy, use of a *prescription drug* list, therapeutic substitution, day/supply limits, and other utilization services. *Your* in-network pharmacist will be told of any rules when *you* fill a prescription, and will be also told about any details *we* need to decide benefits.

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 injectable *drugs*. These are *drugs* that do not need administration or monitoring by a *provider* in an office or facility. Office-based injectables and infused *drugs* that need *provider* administration and/or supervision are covered under the “Prescription drugs administered by a medical provider” benefit;
- Oral chemotherapy drugs when administration or monitoring by a *provider* or in an office or a facility is not required;
- 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 “Wellness services” benefit. Please see that section for more details;
- Special food products or supplements when prescribed by a doctor if *we* agree they are *medically necessary*;
- Flu shots (including administration).
- *Prescription drugs* that help *you* stop smoking or reduce *your* dependence on tobacco products. These drugs will be covered under the “Wellness services” benefit;
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a prescription for a *member* age 18 or older. These products will be covered under the “Wellness services” benefit;

We will not deny prescription drugs (or inpatient or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Additionally, benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been

recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Please see “Experimental/investigative” in the **Definitions** section for additional information about the exception criteria and requirements for these coverage situations.

Where you can get prescription drugs

In-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.

Specialty pharmacy

If you need a *specialty drug*, you or your doctor should order it from the PBM’s specialty *pharmacy*. We keep a list of *specialty drugs* that may be covered based upon clinical findings from the *pharmacy and therapeutics (P&T) process*, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM’s specialty *pharmacy* has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about *specialty drugs*.

When you use the PBM’s specialty *pharmacy* a patient care coordinator will work with you and your doctor to get prior authorization and to ship your *specialty drugs* to you or your doctor’s office. 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 Service at the phone number on the back of your identification card or check our website at www.anthem.com.

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. 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.

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 if 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.

Out-of-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. (*Out-of-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 *out-of-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 out-of-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 full price of the drug. Reimbursement to you 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.

Services of non-participating pharmacies

Notwithstanding any provision in this booklet to the contrary, you have coverage for outpatient *prescription drug* services provided to you by an out-of-network pharmacy that has previously notified the PBM of its agreement to accept reimbursement for its services at rates applicable to in-network pharmacies including any applicable *copayment, coinsurance* and/or *deductible* (if any) amounts as payment in full to the same extent as coverage for outpatient *prescription drug* services provided to you by an in-network provider. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy agreement with the PBM or its designee within thirty days of being requested to do so in writing by the PBM, unless and until the pharmacy executes and delivers the agreement.

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.

- 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*, or multi-source *brand drugs*.
- Tier 2 *drugs* have a higher *coinsurance* or *copayment* than those in Tier 1. This tier contains preferred *drugs* that may be *generic*, single source, or multi-source *brand drugs*.
- Tier 3 drugs have a higher *coinsurance* or *copayment* than those in Tier 2. This tier contains non-preferred and high cost drugs. This includes drugs considered *generic*, single source brands, and multi-source brands.
- Tier 4 drugs have a higher *coinsurance* or *copayment* than those in Tier 3.

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., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier. We will provide at least 30 days prior written notice of any modification

to a formulary that results in the movement of a *prescription drug* to a tier with higher cost-sharing requirements.

Prescription drug list

We also have an *Anthem prescription drug* list, (a formulary), which is a list of FDA-approved drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain drugs if they are not on the *prescription drug* list.

The drug list is developed by us based upon clinical findings, and where proper, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, generic drugs, the use of one drug over another by our members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as *medically necessary*.

There are two exceptions to the formulary requirement:

- You may obtain coverage without additional cost sharing beyond that which is required of formulary *prescription drugs* for a non-formulary drug if we determine, after consultation with the prescribing physician, that the formulary drugs are inappropriate for your condition
- You may obtain coverage without additional cost sharing beyond that which is required of formulary *prescription drugs* for a non-formulary drug if:
 - You have been taking or using the non-formulary *prescription drug* for at least six months prior to its exclusion from the formulary; and
 - The prescribing physician determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

PreventiveRx benefit

Note: The PreventiveRx benefit covers *prescription drugs* in addition to those required by federal law under the “Wellness services” benefit. Any *prescription drugs* covered under the “Wellness services” benefit will not be subject to *copayments*, *deductibles*, or *coinsurance* when you use an in-network provider.

Your plan includes the PreventiveRx benefit. This benefit waives *copayments*, *coinsurance*, and *deductible* amounts (if any) on *prescription drugs* listed in the PreventiveRx Expanded list. These drugs have been found useful in preventing disease or illness. You can get a copy of this list at www.anthem.com. The list will be reviewed and updated from time to time.

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 **Summary of 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.

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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.

Special programs

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.

What is not covered (Exclusions)

This list of services and supplies that are excluded from coverage by *your health plan* will not be covered in any case.

A

Your coverage does not include benefits for **acupuncture**.

B

Your coverage does not include benefits for **biofeedback therapy**.

C

Your coverage does not include benefits for:

- over the counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags; or
- benefits for, or related to, **cosmetic surgery or procedures**, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

Your coverage does not include benefits for the following **dental** or oral surgery services:

- shortening or lengthening of the mandible or maxillae for cosmetic purposes;
- surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services;
- dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia;
- medications to treat periodontal disease;
- treatment of natural teeth due to diseases;
- treatment of natural teeth due to accidental injury unless you submitted a treatment plan to us for prior approval. No approval of a plan of treatment by us is required for emergency treatment of a dental injury;
- biting and chewing related injuries unless the biting or chewing results from a medical or mental condition;
- restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth, unless required to treat an accidental injury;

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- extraction of either erupted or impacted wisdom teeth;
- anesthesia and hospitalization for dental procedures and services except as specified in the **What is covered** section of this booklet;
- oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures; or
- periodontal care, prosthodontal care or orthodontic care.

This exclusion will not apply if your group's coverage includes a dental rider.

Your coverage does not include benefits for **donor** searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling).

E

Your coverage does not include benefits for services or supplies primarily for **educational**, vocational, or self management training purposes, except as otherwise specified in this benefit booklet or when received as part of a covered wellness services visit or screening.

Your coverage does not include benefits for **experimental/investigative** procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer. The criteria for deciding whether a service is experimental/investigative or a clinical trial cost for cancer is set forth in **Exhibit A**.

F

Your coverage does not include benefits for the following **family planning** services:

- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- any services or supplies provided to a person not covered under your health plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);
- drugs used to treat infertility; or
- services to reverse voluntarily induced sterility.

Your coverage does not include benefits for palliative or cosmetic foot care including:

- flat foot conditions;
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- foot orthotics;
- subluxations of the foot;
- corns (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except as treatment for patients with diabetes or vascular disease);
- care of toenails (except as treatment for patients with diabetes or vascular disease);
- fallen arches;

- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

G

Your coverage does not include services for surgical treatments of **gynecomastia** for cosmetic purposes.

H

Your coverage does not include benefits for **health club memberships**, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Your coverage does not include benefits for **hearing** aids or for examinations to prescribe or fit hearing aids, unless otherwise specified in this benefit booklet.

Your coverage does not include benefits for the following **home care** services:

- homemaker services;
- maintenance therapy;
- food and home delivered meals; or
- custodial care and services.

Your coverage does not include benefits for the following **hospital** services:

- guest meals, telephones, televisions, and any other convenience items received as part of your *inpatient stay*;
- care by interns, residents, house physicians, or other *facility* employees that are billed separately from the *facility*; or
- a private room unless it is *medically necessary*.

I

Your coverage does not include benefits for **immunizations** required for travel and work, unless such services are received as part of the covered preventive care services as defined in the **What is covered** section of this book.

M

Your coverage does not include benefits for **medical equipment (durable), appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use. These include:

- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;

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- hypoallergenic bed linens;
- whirlpool baths;
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- foot orthotics;
- changes made to a home or place of business; or
- repair or replacement of equipment you lose or damage through neglect.

Your coverage does not include benefits for *medical equipment (durable)* that is not appropriate for use in the home.

Your coverage does not include benefits for services and supplies if they are deemed not **medically necessary** as determined by Anthem at its sole discretion. Nothing in this exclusion shall prevent you from appealing Anthem's decision that a service is not *medically necessary*.

However, if you receive *inpatient* or *outpatient* services that are denied as not *medically necessary*, or are denied for failure to obtain the required pre-authorization, the following professional provider services that you receive during your *inpatient stay* or as part of your *outpatient* services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:

For inpatients

1. services that are rendered by professional providers who do not control whether you are treated on an *inpatient* basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than *inpatient* evaluation and management services provided to you. *Inpatient* evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. *Inpatient* evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

For *outpatients* - services of pathologists, radiologists and anesthesiologists rendering services in an (i) *outpatient* hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician.

Your coverage does not include benefits for the following **mental health services and substance use disorder services**:

- *inpatient* stays for environmental changes;
- cognitive rehabilitation therapy;
- educational therapy;
- vocational and recreational activities;
- coma stimulation therapy;
- services for sexual deviation and dysfunction;
- treatment of social maladjustment without signs of a psychiatric disorder; or
- remedial or special education services.

N

Your coverage does not include benefits for **nutrition** counseling and related services, except when provided as part of diabetes education, for the treatment of an eating disorder, or when received as part of a covered wellness services visit or screening.

Your coverage does not include benefits for **nutritional and/or dietary supplements**, except as provided under *your health plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

O

Your coverage does **not** include benefits for services and supplies related to **obesity** or services related to **weight loss** or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

Your coverage does not include benefits for **organ** or tissue transplants, including complications caused by them, except as outlined in the **What is covered** section of this book.

P

Your coverage does not include benefits for **paternity testing**.

Your coverage does not include benefits for **private duty nurses** in the *inpatient* setting.

R

Your coverage does not include benefits for rest cures, custodial, **residential**, or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services.

S

Your coverage does not include benefits for **services or supplies** if they are:

- ordered by a doctor whose services are not covered under *your health plan*;
- care of any type given along with the services of an attending *provider* whose services are not covered;
- benefits for charges from stand-by physicians in the absence of *covered services* being rendered;

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- not listed as covered under *your health plan*;
- services received from providers not licensed by law to provide covered services defined in this booklet. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers;
- not prescribed, performed, or directed by a *provider* licensed to do so;
- received before the *effective date* or *after a covered person's coverage ends*;
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms;
- for travel, whether or not recommended by a physician;
- services prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not *you* waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted;
- provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- received from an employer mutual association, trust, or a labor union's dental or medical department;
- for injuries or illnesses incurred as a result of your commission of, or attempt to commit, a crime; or
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

Your coverage does not include benefits for **services** for which a charge is not usually made. This includes services for which *you* would not have been charged if *you* did not have health care coverage.

Your coverage does not include benefits for:

- amounts above the *maximum allowed amount* for a service; or
- biofeedback, neurofeedback, and related diagnostic tests.

Your coverage does not include benefits for surgeries for **sexual dysfunction**. In addition, your coverage does not include benefits for services for **sex transformation**. This includes medical and mental health services.

Your coverage does not include benefits for the following **skilled nursing facility stays**:

- treatment of psychiatric conditions and senile deterioration;
- *facility* services during a temporary leave of absence from the *facility*; or
- a private room, unless it is *medically necessary*.

Your coverage does not include benefits for **smoking cessation** programs not affiliated with us.

Your coverage does not include benefits for **spinal manipulations** or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

T

Your coverage does not include benefits for non-interactive **telemedicine services**. Non-interactive telemedicine services include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Your coverage does not include benefits for the following **therapies**:

- **physical therapy, occupational therapy, or speech therapy** to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;
- group speech therapy;
- group or individual exercise classes or personal training sessions; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

V

Your coverage does not include services for treatment of varicose **veins** or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Your coverage does not include benefits for the following **vision** services:

- vision services or supplies unless needed due to eye surgery and accidental injury;
- services for radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury;
- sunglasses of any type;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer; or
- any other vision services not specifically listed as covered.

W

Your coverage does not include benefits for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered under your health plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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Your coverage does not include benefits for services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if *you* waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the *covered person* reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

What's not covered under your prescription drug retail or home delivery (mail order) pharmacy benefit

In addition to the above exclusions, certain items are not covered under the prescription drug retail or home delivery (mail order) pharmacy benefit:

Administration charges - Charges for the administration of any drug except for covered immunizations as approved by us or the PBM.

Compound drugs unless the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer.

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 or drugs covered under the medical supplies benefit – they are *covered services*.

Drugs not on the Anthem prescription drug list (a formulary). *You* can get a copy of the list by calling us or visiting our website at www.anthem.com.

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.

Drugs over quantity or age limits. Drugs in quantities which are over the limits set by the plan, 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.

Fluoride treatments, topical and oral fluoride treatments.

Infertility drugs. *Drugs* used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).

Items covered as durable medical equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the *prescription drug* benefit at a retail or home delivery (mail order) pharmacy benefit may be covered under the medical equipment (durable) and medical devices, prosthetics, and appliances benefit. Please see that section for details.

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Items covered as medical supplies - Oral immunizations and biologicals, even if they are federal legend drugs, are covered as medical supplies based on where you get the service or item. Over-the-counter drugs, devices or products, are not covered services unless we must cover them under federal law.

Items covered under the medical supplies and medications benefit. Allergy desensitization products or allergy serum. While not covered under the “Prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy” benefit, these items may be covered under the “Medical supplies and medications” benefit. Please see that section for details.

Mail order providers other than the PBM’s home delivery mail order provider. *Prescription drugs* dispensed by any mail order provider other than the PBM’s home delivery mail order provider, unless we must cover them by law.

Non-approved drugs. Drugs not approved by the FDA.

Off label use, unless we must cover the use by law or if we, or the PBM, approve it. The exception to this exclusion is described in “Covered prescription drugs” in the “Prescription drug benefit at a retail or home delivery (mail order) pharmacy” section.

Onychomycosis drugs. Drugs for onychomycosis (toenail fungus), except when we allow it to treat members who are immune-compromised or diabetic.

Over-the-counter items. Drugs, devices and products, or prescription legend drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product. This includes prescription legend drugs when any version or strength becomes available over the counter. This exclusion does not apply to over-the-counter products that we must cover under federal law with a prescription.

Sex change drugs. Drugs for sex change surgery.

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.

Claims and payments

Your *health plan* considers the charge 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. Also, the dates of service will affect your *deductible* (if any) and other minimums described in the **Summary of benefits** and in this section.

Plan year deductible

Your benefits include a plan year *deductible* for *covered services* that *you* receive. Both in-network and *out-of-network* services accumulate toward the plan year *deductible*. Before we will make payments for *covered services* other than in-network wellness services, *you* must first satisfy the plan year *deductible*. See the **Summary of benefits** section of this booklet for the amount of your plan year *deductible*.

Limits on your out-of-pocket expenses

Your *health plan* protects *you* from large out-of-pocket expenses by limiting the amount *you* spend out of your own pocket each year. Once the limit on your *health plan* is reached, almost all other covered expenses are paid in full for the rest of the plan year.

What you will pay

In-network limit

Deductible amounts for in-network and *out-of-network* services as well as *coinsurance* for services by *providers* and *facilities* within your network count toward your in-network, out-of-pocket expense limit. *Deductible* and *coinsurance* amounts for *prescription drugs* under your *prescription drug* benefit will always apply toward the *in-network* limit, even when your prescription is filled by a pharmacy outside *Anthem's* pharmacy network. When your in-network, out-of-pocket expense limit is reached, *deductibles* and *coinsurance* for in-network services will no longer apply for the rest of the plan year. Two special situations when expenses will also count toward this limit are:

- when *you* receive services from medical suppliers for whom there is no network (e.g., private duty nurses), your out-of-pocket expenses count toward this limit; and
- when specialty care is not available within the network and *Anthem* authorizes the highest level of benefits, any *deductibles* and *coinsurance* for these *covered services* count toward this limit.

Out-of-network limit

Deductible amounts for in-network and *out-of-network* services as well as *coinsurance* for *covered services* by *providers* and *facilities* who are not part of your *KeyCare PPO Network*, but who participate in an *Anthem* or Blue Cross and Blue Shield Company's network, count toward your *out-of-network*, out-of-pocket expense limit. If *you* reach your *out-of-network*, out-of-pocket expense limit, *you* will no longer pay *coinsurance* for *out-of-network* services for the rest of the plan year.

What does not count toward these limits

Cost sharing amounts for covered essential health benefits (defined by federal law) will always count toward these limits. However, the following amounts do not count toward your out-of-pocket expense limit, and you will always be responsible for these expenses, regardless of whether you have met your out-of-pocket expense limit.

- amounts above the *maximum allowed amount*;
- amounts above health plan limits;
- expenses for supplies or services not covered by *your health plan*; or
- *deductible*, *copayments*, and *coinsurance* for dental services provided by separate contract, certificate, or amendment to this health plan.

How Anthem pays a claim

How we pay a claim takes into account the *maximum allowed amount* for the service, the network status of the *provider* or *facility* where you receive services, and your member cost share under *your health plan's* benefit design. Each of the components is explained in the sections that follow. For the purposes of these sections, *providers* also includes *facilities*.

Maximum allowed amount

This section describes how we determine the amount of reimbursement for *covered services*. Reimbursement for services rendered by in-network and *out-of-network providers* is based on *your health plan's maximum allowed amount* for the *covered service* that you received. Please see the BlueCard section for additional information.

The *maximum allowed amount* for *your health plan* is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet our definition of *covered services*, to the extent such services and supplies are covered under *your health plan* and are not excluded;
- that are *medically necessary*; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your plan.

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 non-participating *providers*, 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.

“Per diem amount” means an all inclusive fixed payment amount for each day of admission in an *inpatient facility*.

Maximum allowed amount for multiple procedures

When multiple procedures are performed on the same day by the same physician 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.

Assistant at surgery

Services of a physician who actively assists the operating surgeon to perform a covered surgical service are *covered services*. However, when two or more surgeons provide a covered surgical service that could have been performed by one surgeon, the *maximum allowed amount* will not be more than that available to one surgeon.

Provider network status

The *maximum allowed amount* may vary depending upon whether the *provider* is an in-network *provider* or an *out-of-network provider*.

An in-network *provider* is a *provider* who is in the *KeyCare PPO network*, the managed network for this specific health plan. For *covered services* performed by an in-network *provider*, the *maximum allowed amount* for your health plan is the rate the *provider* has agreed with *Anthem* to accept as reimbursement for the *covered services*.

Providers who are not in the *KeyCare PPO network*, but contracted for other products with us are considered non-network participating *providers*. While your cost share may be higher because these *providers* are not in-network, these non-network participating *providers* have agreed to accept the *maximum allowed amount* established by the *provider's* contract as payment in full for those *covered services*. Choosing an in-network *provider* will likely result in lower out-of-pocket costs to you.

Because in-network providers and non-network participating providers have agreed to accept the *maximum allowed amount* as payment in full for those *covered services*, they should not send you a bill or collect for amounts above the *maximum allowed amount*. However, you may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent you have not met your deductible or have a *copayment* or *coinsurance*. Please call Member Services for help in finding an in-network *provider* or visit www.anthem.com.

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Providers who have not signed any contract with us and are not in any of *our* networks are out-of-network providers. For covered services *you* receive from an *out-of-network provider*, the *maximum allowed amount* for *your health plan* will be one of the following as determined by *Anthem*:

1. an amount based on *our* non-participating *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: statewide average reimbursement amounts that *Anthem* previously has paid for similar claims in the state of Virginia, reimbursement amounts accepted by like/similar *providers* contracted with *Anthem*, reimbursement rates accepted by *providers* under the last network contract in effect with *Anthem*, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data or
2. an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the *maximum allowed amount* upon the level and/or method of reimbursement used by the CMS, *Anthem* will update such information, no less than annually; or
3. an amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable *providers’* fees and costs to deliver care; or
4. an amount negotiated by *us* or a third party vendor which has been agreed to by the *provider*. This may include rates for services coordinated through case management; or
5. an amount based on or derived from the total charges billed by the out-of-network provider.

A per diem amount may be used in calculating the *maximum allowed amount* for *inpatient facility* services. When calculating these amounts, the charges for non-covered services are subtracted from the per diem amount.

Member Services is also available to assist *you* in determining *your health plan’s maximum allowed amount* for a particular service from an *out-of-network provider*. In order for us to assist *you*, *you* will need to obtain from your *provider* the specific procedure code(s) and diagnosis code(s) for the services the *provider* will render. *You* will also need to know the *provider’s* charges to calculate your out-of-pocket responsibility. Although Member Services can assist *you* with this pre-service information, the final *maximum allowed amount* for your claim will be based on the actual claim submitted by the *provider*.

Certain *covered services* such as medical supplies, ambulance, early intervention services, *home care services*, private duty nursing, medical equipment, and medical formulas, may be rendered by persons or entities that are not *providers*. There may or may not be networks established for these persons or entities. The *maximum allowed amount* for services from these persons or entities will be determined in the same manner as described above for *providers*. For *prescription drugs* and diabetic supplies rendered by a pharmacy, the *maximum allowed amount* is the amount determined by *us* using prescription drug cost information provided by *our* pharmacy benefits manager.

Member cost share

For certain *covered services* and depending on your plan's benefit design, *you* may be required to pay a part of the *maximum allowed amount* as your cost share amount (for example, *deductible*, *copayment*, and/or *coinsurance*).

Your cost share amount and out-of-pocket limits may vary depending on whether *you* received services from an in-network or *out-of-network provider*. Specifically, *you* may be required to pay higher cost sharing amounts or may have limits on your benefits when using *out-of-network providers*. Please see the **Summary of benefits** in this certificate 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.

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 an in-network or *out-of-network provider*. Both services specifically excluded by the terms of your policy/plan and those received after benefits have been exhausted are non-*covered services*. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits. The *maximum allowed amount* for *inpatient facility services* may be based on a per diem amount. When calculating these amounts, the charges for non-*covered services* are subtracted from the per diem amount.

In some instances, *you* may only be asked to pay the lower in-network cost sharing amount when *you* use an *out-of-network provider*. For example, if *you* go to an in-network hospital or *provider facility* and receive *covered services* from an *out-of-network provider* such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an in-network hospital or *facility*, *you* will pay the in-network cost share amounts for those *covered services*. However, *you* also may be liable for the difference between the *maximum allowed amount* and the *out-of-network provider's* charge.

In some instances, because of the negotiated arrangement with network *facilities* and *providers*, our *maximum allowed amount* may be higher than the *facility* or *provider* billed charge for the *covered services*. In these cases, any *coinsurance* amount that *your health plan* imposes will be based off the lower billed charges.

Note: The following examples are illustrative only, and are not intended to reflect the actual member cost share amounts reflected on the **Summary of benefits**.

Example: Your plan has a *coinsurance* cost share of 20% for in-network services, and 30% *out-of-network* after the in- or *out-of-network deductible* has been met. *You* undergo a surgical procedure in an in-network hospital. The hospital has contracted with an *out-of-network* anesthesiologist to perform the anesthesiology services for the surgery. *You* have no control over the anesthesiologist used.

- the *out-of-network* anesthesiologist's charge for the service is \$1200. The *maximum allowed amount* for the anesthesiology service is \$950; your *coinsurance* responsibility is 20% of \$950, or \$190 and the remaining allowance from us is 80% of \$950, or \$760. *You* may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the *deductible* has been met,

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your total out-of-pocket responsibility would be \$190 (20% *coinsurance* responsibility) plus an additional \$250, for a total of \$440.

- you choose an in-network surgeon. The charge was \$2500. The *maximum allowed amount* for the surgery is \$1500; your *coinsurance* responsibility when an in-network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The in-network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out-of-pocket responsibility would be \$300.
- you choose an *out-of-network* surgeon. The *out-of-network* surgeon's charge for the service is \$2500. The *maximum allowed amount* for the surgery service is \$1500; your *coinsurance* responsibility for the *out-of-network* surgeon is 30% of \$1500, or \$450 after the *out-of-network deductible* has been met. We allow the remaining 70% of \$1500, or \$1050. In addition, the *out-of-network* surgeon could bill you the difference between \$2500 and \$1500, so your total out-of-pocket charge would be \$450 plus an additional \$1000, for a total of \$1450.

Authorized services

In some circumstances, such as where there is no in-network *provider* available for the *covered service*, we may authorize the network cost share amounts (*deductible*, *copayment*, and/or *coinsurance*) to apply to a claim for a *covered service* you receive from an *out-of-network provider*. In such a circumstance, 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 an *out-of-network provider* and are not able to contact us until after the *covered service* is rendered. If we authorize a *covered service* so that you are responsible for the in-network cost share amounts, you may still be liable for the difference between the *maximum allowed amount* and the *out-of-network provider's* charge. Please contact Member Services for authorized services information or to request authorization.

Example: You require the services of a specialty *provider*, but there are no in-network *providers* for that specialty in your state of residence. You contact us in advance of receiving any *covered services*, and we authorize you to go to an available *out-of-network provider* for that *covered service* and we agree that the in-network cost share will apply.

Your plan has a \$45 *copayment* for *out-of-network providers* and a \$25 *copayment* for in-network *providers* for the *covered service*. The *out-of-network provider's* charge for this service is \$500. The *maximum allowed amount* is \$200.

Because we have authorized the in-network cost share amount to apply in this situation, you will be responsible for the in-network *copayment* of \$25 and Anthem will be responsible for the remaining \$175 of the \$200 *maximum allowed amount*.

Because the *out-of-network provider's* charge for this service is \$500, you may receive a bill from the *out-of-network provider* for the difference between the \$500 charge and the *maximum allowed amount* of \$200. Combined with your in-network *copayment* of \$25, your total out-of-pocket expense would be \$325.

Claims review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other

inappropriate activity. Members seeking services from *out-of-network providers* could be balanced billed by the *out-of-network provider* for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

Network and participating providers and facilities

If you go to a network or participating *provider* or *facility*, we will pay the *provider* or *facility* directly. If *coinsurance* or a *copayment* is applicable to *covered services* rendered by a network or participating *facility* or *provider*, or if any applicable *deductible* is not met, any such amounts may be collected at the time of service.

Non-participating providers and facilities

If you go to a non-participating *provider* or *facility*, we may choose to pay you or anyone else responsible for paying the bill. We will pay only after we have received an itemized bill or proof of loss and all the medical information we need to process the claim. We will not pay a non-participating *provider* more than we would have paid a participating *provider* for the same service.

In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-participating *provider*.

When you must file a claim

Network *providers* file claims on your behalf. You may have to file a claim if you receive care from a *provider* or *facility* that does not participate in Anthem's network.

You will have to file a claim if you receive care billed by someone other than a doctor or hospital, or if the *provider* cannot file a claim for you. To file a claim follow these 3 steps:

1. Call 800-582-6941 to order a claim form or get one from your *group administrator*.
2. Please include the completed and signed claim form and any itemized bills for *covered services*. Each itemized bill must contain the following:
 - name and address of the person or organization providing services or supplies;
 - name of the patient receiving services or supplies;
 - date services or supplies were provided;
 - the charge for each type of service or supply;
 - a description of the services or supplies received; and
 - a description of the patient's condition (diagnosis).

In addition, private duty nursing bills must include the professional status of the nurse (for example, RN for registered nurse), the attending physician's written certification that the services were *medically necessary*, and the hours the nurse worked.

3. Send the completed claim form and any itemized bills for *covered services* to:

Anthem Blue Cross and Blue Shield
P. O. Box 27401
Richmond, VA 23279

Timely filing of claims

Written proof of loss must be furnished within 90 days after the date of service. A proof of loss is not complete unless it is properly filed and contains all information that *Anthem* needs to process the claim. Failure to furnish the proof of loss within this time frame will not invalidate or reduce any claim if the proof of loss is given as soon as reasonably possible. However, no claim will be paid if we receive the proof of loss more than 15 months after the date of service, except in the absence of legal capacity of the *covered person*.

When your claim is processed

Once a claim has been processed, if your portion of the bill is anything other than zero or equal to a flat *copayment* amount, a paper copy of the Explanation of Benefits (EOB) statement will be mailed to *you* to explain your responsibility. In the event that your portion of the bill is zero or equal to a flat *copayment* amount, the paper copy will not be mailed, but will be available to *you* online at www.anthem.com. If *you* do not have access to the Internet, *you* may contact Member Services to arrange for a printed copy.

In processing your claim, *your health plan* may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the **“When you must file a claim”** paragraph of this section will be processed within 30 days of receipt of the claim. We may extend this period for another 15 days if we determine it to be necessary because of matters beyond *our* control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 30-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, we will make *our* decision within 2 working days of *our* receipt of the medical information needed to process the claim.

Your health plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by *you* or your *provider* furnishing the additional information. *You* or your *provider* must submit the additional information to us within either 15 months of the date of service or 45 days from the date *you* were notified that the information is needed, whichever is later. Once your claim has been processed by *your health plan*, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination*, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *your health plan's* appeal procedures and applicable time limits; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that may assist *you* with the internal or external appeals process.

If all or part of a claim was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that *your health plan* relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, *you* are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

Recovery of overpayments

Anthem shall have the right to recover any overpayment of benefits from persons or organizations that *we* have determined to have realized benefits from the overpayment:

- any person to, or for whom, such payments were made;
- any insurance company;
- a facility or provider; or
- any other organization.

You will be required to cooperate with *us* to secure *Anthem's* right to recover the excess payments made on your behalf, or on behalf of *covered persons* enrolled under your family coverage.

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

When you are covered by more than one health plan

Coordination of benefits (COB)

All benefits provided under this health plan are subject to special coordination of benefits (COB) rules that apply when you or members of your family have additional health care coverage through other group health plans. Benefits will not be increased by this COB provision, and this provision applies if the total payment under this plan, absent this provision and under any other contract, is greater than the value of covered services. Other coverage means any arrangement providing health care benefits or services, including:

- group or blanket insurance plans, including other group Blue Cross and Blue Shield plans, health maintenance organization (HMO) plans, and other prepayment coverage;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

If there is more than one form of other coverage, this provision will apply separately to each. If the other coverage has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

Anthem will not determine the existence of any other coverage, or the amount of benefits payable under any other coverage except this health plan. The payment of benefits under this health plan shall be affected by the benefits payable under other coverage only when *Anthem* is given information about the other coverage.

If the rules of this health plan and the other coverage both provide that this health plan is primary, then this health plan is primary. When *Anthem* determines that this health plan is secondary under the rules described below, benefits will be reduced so that our payment plus the other contract's payment will not exceed *Anthem's maximum allowed amount* for covered services.

If you are enrolled in a qualified high *deductible* health plan for purposes of the Health Savings Account provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and Section 223 of the Internal Revenue Code, any other coverage you have must also satisfy the requirements for qualified high *deductible* health plans, so as not to affect your tax status. In the event of coverage under more than one health plan, please seek the counsel of a tax advisor.

Primary coverage and secondary coverage

When a *covered person* is also enrolled in another group health plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the following order of benefit determination rules:

- If coverage under a contract is taken out in the name of a covered person, then that contract will be primary for that covered person. However, if the person is also entitled to Medicare, and as a result of federal law Medicare is:
 - secondary to the contract covering the person as a dependent; and
 - primary to the contract covering the person as other than a dependent (e.g. a retired employee);
- then the benefits of the contract covering the person as a dependent are determined before those of the contract covering the person as other than a dependent.
- For children who are covered under both parents' contracts, the following will apply:
 - The contract of the parent whose birthday occurs earlier in the calendar year will be primary.
 - When parents are separated or divorced, the following special rules will apply:
 - If the parent with custody has not remarried, that parent's contract will be primary.
 - If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract of the parent without custody will be determined last.
- The rules listed above may be changed by a court decree:
 - A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
 - If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.
 - If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.
 - If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working employee (or his dependent) will be primary. The policy or plan of a laid-off employee, a retired employee, or a person on continuation of coverage options under federal or state law will be secondary.
- If another policy or plan has different rules from those listed above other than the gender rule, that policy or plan will be primary.

When this health plan provides secondary coverage, we first calculate the amount that would have been payable had this health plan been primary. In no event will this health plan's payment as secondary coverage exceed that amount. This health plan coordinates benefits so that the combination of the primary plan's payment and this health plan's payment does not exceed *our maximum allowed amount*. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment.

The preceding paragraph does not apply to claims for *outpatient prescription drugs* provided by a pharmacy when Medicare Part D provides the covered person's primary prescription drug coverage. See the following section for more information.

How prescription drug benefits are coordinated when Medicare Part D is primary

If Medicare Part D provides your primary coverage for *outpatient prescription drugs* provided by a pharmacy, we first calculate the amount that would have been payable had this health plan been primary. We then pay a secondary benefit up to that amount, in order to reduce any amount you had

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to pay out of pocket under Medicare Part D. The benefit we pay is limited to the lesser of the amount you paid out-of-pocket under Medicare Part D or the amount this health plan would have paid if it had been primary.

Changing your coverage

Who is eligible for coverage

You

You are eligible for coverage after *you* satisfy your employer's eligibility requirements. Eligibility requirements are available from your *group administrator*. Your employer will inform *you* of your *effective date* in accordance with these eligibility requirements.

Your eligible dependents

Eligible dependents include:

- Your spouse. For information on spousal eligibility, please contact your group administrator;
- Your children age 26 or younger which includes :
 - a newborn, natural child, or a child placed with *you* for adoption;
 - a stepchild; or
 - any other child for whom *you* have legal guardianship or court-ordered custody.

The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.

The age limit does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if *you* provide proof of handicap and dependence at the time of enrollment.

You may be asked to provide a physician's certification of the dependent's condition.

Types of coverage

Your employer provides the following enrollment options. After reviewing the available options, *you* may choose the option that best meets your needs. The options are as follows:

- Employee only;
- Employee and spouse;
- Employee and one child;
- Employee and family; and
- Employee and children.

When you may enroll

You may enroll:

- **During the initial enrollment period**

If your employer has purchased a new group policy from *Anthem* and you were enrolled under a previous group policy of that employer on the date before this group policy is effective, your *effective date* will be the date the health plan begins. Your *group administrator* can tell you what this date is.

- **Within 31 days after becoming eligible**

Your *effective date* will be the first of the month after the date you become eligible.

- **During annual open enrollment periods**

Your employer will tell you the *effective date* if you enroll during your company's annual open enrollment period.

- **During a special enrollment period**

You may have chosen to decline coverage for yourself and/or dependents under this health plan when you could have enrolled for it because of coverage under another health plan.

If you declined coverage under this health plan in writing for yourself and/or your eligible dependents and later you or your dependent(s) loses the other coverage, you may enroll in any benefit package under the plan during a special enrollment period. For example, a special enrollment period of 31 days will be allowed if:

- the other health plan coverage was under a COBRA continuation and the continuation period ran out;
- the employer who had been making contributions toward the other health plan coverage stopped making them; or
- there was a loss of eligibility under the other health plan coverage. Eligibility may have been lost due to:
 - divorce;
 - the death of your spouse;
 - a reduction in the number of hours of employment;
 - termination of employment for yourself or your spouse at another company; or
 - for a dependent, cessation of dependent status.

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

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

Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

If your family changes

Special enrollment periods are also allowed if your family changes. The change may be due to your marriage, the birth of a child, or the placement of a child with *you* for adoption. Within 31 days after the change occurs, *you* will need to complete an application to add dependents or a change form to delete dependents. In all cases, contact your *group administrator* immediately.

Marriage

The *effective date* of coverage for those added as a result of marriage will be determined by your employer in accordance with its eligibility requirements.

Newborn and adopted dependents

If *you* enroll a newborn dependent during the special enrollment period following his or her birth, the newborn's coverage will begin on his or her date of birth. If *you* enroll a dependent placed with *you* for adoption during the special enrollment period following his or her placement, the dependent is covered from the date of placement. If a newborn is placed for adoption within 31 days of birth, coverage is effective from the moment of birth.

When a dependent is no longer eligible for coverage, *you* can change your type of coverage by completing a change form to drop the dependent. *We* will change your coverage the first day of the month after *you* submit a change form.

After coverage ends

When a *covered person* ceases to be eligible or the required premiums are not paid, the *covered person's* coverage will end. Unless otherwise agreed to in writing by *Anthem*, the *covered person's* coverage ends on the last day of the month for which payment is made, in accordance with grace period provisions. The *covered person's* coverage ends on the last day of the month during which eligibility ceases.

Examples of when a *covered person's* eligibility may cease include:

- when you leave your job with the employer.
- when a child reaches the end of the month in which the child turns 26.
- in the case of a handicapped dependent, when the child is no longer handicapped.
- when an enrolled child over age 26 marries.
- in the case of your spouse, when *you* and your spouse divorce.

After you become eligible for Medicare

If *you* continue to work after becoming eligible for Medicare due to age (usually at age 65), your Medicare entitlement will not end your eligibility for coverage under this health plan. When you retire, you will no longer be eligible for coverage under the group plan. You may be able to apply for a COBRA continuation of coverage (see “Continuation of Coverage (COBRA)” section below). If you are entitled to Medicare, you may also be eligible for an individual Medicare supplement plan.

To enroll for Medicare when *you* or a family member becomes eligible for it, *you* must contact the nearest Social Security Office.

When the employee dies

Coverage continues until the last day of the month in which the employee's death occurs unless your family member(s) are eligible for and elect continuous coverage. (See **Continuation of coverage (COBRA)** below.) Your family members are also eligible for an individual policy through *Anthem*.

Continuing coverage when eligibility ends

A subscriber and enrolled dependents may be eligible for continuous group coverage under the COBRA law (Consolidated Omnibus Budget Reconciliation Act) or twelve-month continuation.

Continuation of coverage (COBRA)

This section pertains to *you* only if your employer's group health plan is subject to the requirements of the COBRA law. It generally explains when COBRA continuation coverage may be available to *you* and your covered family members and what *you* need to do to protect your family's COBRA rights.

COBRA continuation is a temporary extension of coverage under *your health plan*. You and your covered family members may be *qualified beneficiaries*. A *qualified beneficiary* is eligible for continued coverage if coverage under *your health plan* would ordinarily end due to a *qualifying event* described in this section. *Qualified beneficiaries* who elect COBRA coverage must pay the full cost for it, without contribution from the employer.

A *covered person* will become a *qualified beneficiary* if he or she loses coverage under *your health plan* because one of the following *qualifying events* occurs:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You die;
- You become entitled to Medicare benefits;
- You become divorced or legally separated;
- For a covered child, he or she stops being an eligible dependent (for example, by attaining the maximum age for coverage); or
- For covered retirees and their covered family members only, the employer files a proceeding in bankruptcy.

COBRA continuation will be offered only after the *plan administrator* has been notified that a *qualifying event* has occurred. The employer will notify the *plan administrator* unless the *qualifying event* is your divorce or legal separation or the loss of a covered child's eligibility. For these *qualifying events*, you must notify the *plan administrator* within 60 days after the *qualifying event*. The form and content of all COBRA-related notices must satisfy your employer's requirements. Contact your *group administrator* for instructions.

After receiving timely notice, the *plan administrator* will inform the *qualified beneficiaries* of their right to elect continuation of coverage and of:

- the monthly cost for the coverage;
- the due date of each monthly payment; and
- where the monthly payments should be sent.

Qualified beneficiaries have 60 days in which to elect COBRA continuation using forms that have been approved by *Anthem* and supplied by the *plan administrator*. Each *qualified beneficiary* has an independent right to elect COBRA coverage. You may elect COBRA on behalf of your covered spouse, and parents may elect it on behalf of their covered children.

Within 45 days after electing COBRA, the first payment for the coverage must be paid in full, along with any unpaid amounts necessary to pay for coverage through the current month. Thereafter, monthly payments must be made according to the instructions provided by the *plan administrator*.

When the *qualifying event* is:

- your death, divorce, legal separation or Medicare entitlement or a covered child's loss of eligibility, continuation coverage may last up to 36 months.
- a reduction in your work hours or your termination of employment, continuation coverage may last up to 18 months. However, if you became entitled to Medicare less than 18 months before one of

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these *qualifying events*, continuation coverage may last up to 36 months after the date of Medicare entitlement for *qualified beneficiaries* other than *you*.

If a *qualified beneficiary* would ordinarily be eligible for 18 months of continuation coverage, that period may be extended for up to 11 additional months if he or she is determined by the Social Security Administration to have been disabled at some time during the first 60 days of COBRA coverage. To be eligible for the 11-month extension, notice must be provided to the *plan administrator*:

- within 60 days after the date of the Social Security Administration's disability determination; and
- before the end of the first 18 months of COBRA coverage.

Other covered non-disabled family members of the disabled *qualified beneficiary* are also entitled to the 11-month extension if these requirements are met.

If your family experiences another *qualifying event* while receiving 18 months of COBRA continuation coverage, your covered spouse and child(ren) can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if:

- notice of the second *qualifying event* is properly given to the *plan administrator*; and
- the *qualifying event* would have caused the spouse or child(ren) to lose coverage under *your health plan* had the first *qualifying event* not occurred.

If *you* have a newborn child, adopt a child, or have a child placed with *you* for adoption during your COBRA continuation period, that child will also be a *qualified beneficiary* with COBRA rights. For adding a child or making other changes in dependent coverage, please follow the procedures explained earlier in this booklet.

A *qualified beneficiary's* eligibility for COBRA coverage will end on the earliest of the following dates:

- the date that ends the maximum continuation period described above;
- the date that ends the last period for which a monthly payment was made when due;
- the date a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;
- the date the *qualified beneficiary* becomes enrolled in Medicare; or
- the date the employer's group health plan ends.

Once eligibility for COBRA coverage ends, the former *qualified beneficiary* may enroll under any individual program offered by us for which he or she is eligible as explained below.

In order to protect your family's COBRA rights, *you* must keep the *plan administrator* informed of any changes in the addresses of family members. *You* should also keep a copy, for your records, of any notices *you* send to the *plan administrator*.

If *you* have any questions, please contact the *plan administrator*. For additional information, *you* may also contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of EBSA offices are available on EBSA's website.

Other coverage options besides COBRA continuation coverage

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

Important information about your health plan

Statement of ERISA rights

As a participant in this plan *you* are entitled to certain rights and protections under applicable portions of the Employee Retirement Income Security Act of 1974 (ERISA) and/or the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These rights and protections may include the following:

Your right to examine, without charge, at your *plan administrator's* office and at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by the plan with the Department of Labor (such as detailed annual reports), and plan descriptions.

Your right to obtain copies of all plan documents and other plan information by writing to your *plan administrator*. The administrator may make a reasonable charge for the copies.

Note: ERISA generally does not apply to church plans or to governmental plans (such as plans sponsored by city, county, or state governments, or by public school systems).

Plan "fiduciaries"

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

- No one may terminate your employment or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising your rights under ERISA.
- If your claim for a welfare benefit is denied in whole or in part, *you* may receive a written explanation of the reason for the denial.
- *You* have the right to have the *plan administrator* review and reconsider your claim.

Enforcement of ERISA rights

Under ERISA, there are steps to enforce the above rights. For instance:

- If *you* request materials to which *you* are entitled from the plan and do not receive them within 30 days, *you* may file suit in a federal court. In such a case, the court may require the *plan administrator* to provide the materials and pay *you* up to \$110 a day until *you* receive the materials (unless the materials were not sent because of reasons beyond the control of the administrator).
- If *you* have a claim for benefits or an appeal of a coverage decision, which is denied or ignored, in whole or in part, *you* may file suit in a state or federal court.
- If plan fiduciaries misuse the plan's money or if *you* are discriminated against for asserting your rights, *you* may seek assistance from the U.S. Department of Labor, or *you* may file suit in a federal court. The court decides who pays court costs and legal fees.

If *you* are successful, the court may order the person *you* have sued to pay these costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, if, for example, it finds your claim to be frivolous.

Assistance

If *you* have questions about your plan, contact your *plan administrator*. If *you* have questions about this statement about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor, listed in your telephone directory. *You* may also contact the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Changes in the health plan

Your employer may amend this health plan at any time. Any amendment to the health plan will change *covered services* to *covered persons* on the *effective date* of the change. This applies even though *you* may have an ongoing condition at the time of the change.

Grievance/appeal and external review procedures

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 ID card. We will try to resolve your complaint informally by talking to your provider or reviewing your claim. If *you* are not satisfied with the resolution of your complaint, *you* have the right to file an appeal, which is defined as follows:

Complaints typically involve issues such as dissatisfaction about your health plan's services, quality of care, the choice of and accessibility to your health plan's providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your health plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint process

Upon receipt, your complaint will be reviewed and investigated. *You* will receive a response within 30 calendar days of *your health plan's* receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, *you* will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to *you* within an additional 30 calendar days.

Important: Written complaints or any questions concerning your health insurance may be filed to the following address:

Anthem Blue Cross and Blue Shield
Attention: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279

Grievance/appeal process

Your health plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions you find unacceptable, whether the decision is a claim denial or a rescission of coverage. A rescission is a retroactive termination of coverage, other than when it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Types of appeals include:

- internal appeals are requests to reconsider rescissions or coverage decisions of pre-service or post-service claims. Expedited appeals are made available when the application of the time period for making pre-service or post-service appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain; and
- external reviews are requests for an independent, external review of coverage decisions made by your health plan through its internal appeal process. More information about this type of appeal may be found in the "Independent external review of adverse utilization review decisions" paragraph of this section.

How to appeal a coverage decision

To appeal a coverage decision, including a rescission, please send a written explanation of why *you* feel the coverage decision was incorrect. *You* or your authorized representative acting on your behalf may submit the written explanation. Alternatively, this information may be provided to a Member Services representative over the phone. This is your opportunity to provide any comments, documents, or information that *you* feel *your health plan* should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- in the case of a claim, the name of the health care professional or *facility* that provided the service, including the date and description of the service provided and the charge.

Important: *You* may contact Member Services with your appeal or any questions concerning your health insurance at the following:

For medical and prescription drug or pharmacy issues:

Anthem Blue Cross and Blue Shield
Attention: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279

Telephone:
800-582-6941

You must file your appeal within either 15 months of the date of service or 180 days of the date *you* were notified of the *adverse benefit determination*, whichever is later.

How your health plan will handle your appeal

In reviewing your appeal, *we* will take into account all the information *you* submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

We will resolve and respond in writing to your appeal within the following time frames:

- For *pre-service claims*, *we* will respond in writing within 30 days after receipt of the request to appeal;
- For *post-service claims* and rescissions, *we* will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, *we* will respond to *you* and your *provider* as soon as possible taking into account your medical condition, but not later than 72 hours from the receipt of the request.

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

When *our* review of your appeal has been completed, *you* will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. *You* will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

External review

If the outcome of the appeal is adverse to *you*, *you* may be eligible for an independent external review pursuant to federal law.

You must submit your request for external review to *us* within four (4) months of the notice of your final adverse determination.

A request for external review must be in writing unless *we* determine that it is not reasonable to require a written statement. *You* do not have to re-send the information that *you* submitted as part of the

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internal appeal. However, *you* are encouraged to submit any additional information that *you* think is important for review.

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

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

All other requests for external review should be submitted in writing unless *we* determine that it is not reasonable to require a written statement. Such requests should be submitted by *you* or your authorized representative to:

Address:

Anthem Blue Cross and Blue Shield
Attention: Grievances and Appeals Department
P.O. Box 27401
Richmond, VA 23279

Telephone:
800-582-6941

Your decision to seek external review will not affect your rights to any other benefits under this health care plan. There is no charge for *you* to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an appeal before filing a lawsuit

You must exhaust the plan's internal appeals procedure (but not an external review) before filing a lawsuit or taking other legal action of any kind against the plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

The plan reserves the right to modify the policies, procedures and time frames in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Notice in writing

Any notice required under this health plan must be in writing. Notice given to your employer will be sent to your employer's address, stated in the group application as provided by the group. Notice given to a *covered person* will be sent, at *our* option, to the plan administrator or to your address as it appears on *our* records. *Anthem*, the plan administrator, or a *covered person* may indicate a new address for giving notice.

Time limits on legal action

No legal action on a claim may be brought against *Anthem* or *your health plan* until after all appeal rights with respect to the claim have been exhausted. No legal action on a claim may be brought more than one year following the date that all appeal rights with respect to the claim have been exhausted. This limit applies to matters relating to this health plan, to our performance under this health plan, or to any statement made by an employee, officer, or director of *Anthem* concerning this health plan or the benefits available to a *covered person*.

Limitations of damages

In the event a *covered person* or his representative sues *Anthem*, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this health plan, the damages shall be limited to the amount of the *covered person's* claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. Under no circumstances shall this provision be construed to limit or preclude any extra contractual damages that may be available to *you* or your representative.

Laws governing this health plan

This health plan is governed by federal laws regulating employer welfare plans.

Anthem's continuing rights

On occasion, *we* may not insist on your strict performance of all terms of this health plan. This does not mean the plan gives up any future rights it has under this health plan.

Anthem's relationship to providers

The choice of a health care *provider* is solely the *covered person's*. *Providers* are neither *Anthem* employees nor agents. *We* can contract with any appropriate *provider* or *facility* to provide services to *you*. *Our* inclusion or exclusion of a *provider* or a *covered facility* in any network is not an indication of the *provider's* or *facility's* quality or skill. *We* make no guarantees about the health of any *providers*. *We* do not furnish *covered services* but only make payment for them when received by *covered persons*.

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We are not liable for any act or omission of any *provider*, nor are we responsible for a *provider's* failure or refusal to render *covered services* to a *covered person*.

Assignment of payment

A *covered person* may not assign the right to receive payment for *covered services*. Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict, *Anthem's* right to direct future payments to a *covered person* or any other entity. This provision does not apply to dentists and oral surgeons.

Once *covered services* are rendered by a *provider*, *Anthem* will not honor requests not to pay the claims submitted by the *provider*. *Anthem* will have no liability to any person because it rejects the request.

Member Rights and Responsibilities

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

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect *us* to keep your personal health information private. This is as long as it follows state and Federal laws and *our* privacy policies.
- Get the information *you* need to help make sure *you* get the most from your health plan, and share your feedback. This includes information on:
 - *our* company and services.
 - *our* network of doctors and other health care providers.
 - your rights and responsibilities.
 - the rules of your health care plan.
 - the way your health plan works.
- Make a complaint or file an appeal about:
 - your plan
 - any care *you* get
 - any *covered service* or benefit ruling that your plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care *you* may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional *provider* about the cause of your illness, your treatment and what may result from it. If *you* don't understand certain information, *you* can choose a person to be with *you* to help *you* understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all plan rules and policies.
- Choose an in-network *primary care physician* (doctor), also called a *PCP*, if your health care plan requires it.
- Treat all doctors, health care *providers* and staff with courtesy and respect.

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

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by this booklet and not by this Member Rights and Responsibilities statement.

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

Definitions

Activities of daily living

means walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

Adverse benefit determination

is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the health plan.

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.

Brand name drug

Prescription drugs that the PBM has classified as brand name drugs through use of an independent proprietary industry database.

Coinsurance

is the percentage of the maximum allowed amount you pay for some covered services.

Copayment

is the fixed dollar amount you pay for some covered services.

Covered persons

are you and enrolled eligible dependents.

Covered services

are those medically necessary hospital and medical services which are described as covered in this certificate and which are performed, prescribed or directed by a physician.

Deductible

is a fixed dollar amount of covered services you pay in a plan year before your health plan will pay for any remaining covered services during that plan year.

Effective date

is the date coverage begins for you and/or your dependents enrolled under the health plan.

Emergency medical condition (Emergency)

is 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:

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- 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

means any service or supply that is judged to be experimental or investigative at Anthem’s sole discretion. Refer to **Exhibit A** for more information.

Facilities are:

- dialysis centers
- home health care agencies
- hospice providers
- hospitals
- skilled nursing facilities

Future Moms

is a program designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery.

Generic drugs

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.

Group administrator

is the benefits administrator at your employer.

High dose

means a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

Home care services

are services rendered in the home setting. Home care includes services such as skilled nursing visits and physical, speech, and occupational therapy for patients confined to their homes. This also means infusion services rendered in the home setting. Infusion services include such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Infusion services rendered in the home setting do not require that the patient is confined to his/her home.

Inpatient

means when you are a bed patient in the hospital.

Inpatient facilities

are settings where patients can spend the night, including hospitals, skilled nursing facilities, partial day programs.

KeyCare PPO Network

is a network of providers and facilities that has agreed to accept Anthem's maximum allowed amount as payment in full for their services (see page 48 for a definition of maximum allowed amount). When you receive care from KeyCare PPO Network providers and facilities, you won't be charged for any outstanding balances beyond your deductible (if any), copayment, and/or coinsurance amount for covered services detailed in the Summary of benefits (see page 1).

Maintenance medications

Please see the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" section for details.

Maximum allowed amount

means the amount on which deductible (if any), copayment, and coinsurance amounts for eligible services are calculated.

Medical equipment (durable)

is used for a medical purpose, can withstand repeated use, and is appropriate for use in your home for activities of daily living purposes.

Medically necessary

to be considered medically necessary, a service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider.

Mental health and substance use disorder

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 use disorder condition.

Out-of-network

is care covered at a lower level of benefits. After you satisfy a plan year deductible, you are responsible for your coinsurance.

Outpatient

is when you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

Outpatient mental health services

are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Partial day services

are used as an alternative to inpatient treatment.

Pharmacy

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

Pharmacy and therapeutics (P&T) process

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

Plan administrator

is your group administrator or the person selected by your employer to administer the continuation of coverage (COBRA) provision.

Post-service claims

are all claims other than pre-service claims and urgent care claims. Post-service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request authorization in advance.

Prescription drugs

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 the following:

- 1) Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.
- 2) Insulin, diabetic supplies, and syringes.

Pre-service claims

are claims for a service where the terms of the health plan require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

Providers are:

- acupuncturists
- audiologists
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers, psychologists, clinical nurse specialists in psychiatric mental health, professional counselors, marriage and family therapists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories
- retail health clinics
- occupational therapists
- opticians
- optometrists
- podiatrists
- registered physical therapists
- speech pathologists

Qualified beneficiary

is a covered person who is eligible for a temporary extension of coverage under your health plan because of the COBRA law.

Qualifying event

is an event that allows you or covered persons enrolled with you to select continuation of coverage under the COBRA law.

Retail health clinic

is a clinic 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 physician’s assistants and nurse practitioners.

Setting

is the place where you receive treatment. It could be your home, your provider's office, a hospital outpatient department, a skilled nursing home, hospital inpatient room, or a partial day program.

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Skilled nursing facility

is a facility licensed by the state in which it operates to provide medically skilled services to inpatients.

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.

Stay

is the period from the admission to the date of discharge from a facility, including hospitals, hospices, and skilled nursing facilities. All facility stays, less than 90 days apart are considered the same stay, and a new inpatient copayment will not apply.

Telemedicine services

means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine services do not include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Urgent care claims

are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain. Notwithstanding any provision of your health plan, services for an emergency medical condition do not require PCP referrals or any type of advance approval.

Visit

a period during which a covered person meets with a provider to receive covered services. If during the course of one visit, multiple types of service are received where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

We, us, our, Anthem

is Anthem Blue Cross and Blue Shield.

You

the enrolled employee.

Your health plan

the Anthem Lumenos plan.

Exhibit A

Experimental/investigative criteria

Experimental/investigative means any service or supply that is judged to be experimental or investigative at Anthem's sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as *experimental/investigative*:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.
 - a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
 - the following three standard reference compendia defined below:
 - 1) American Hospital Formulary Service – Drug Information
 - 2) National Comprehensive Cancer Network's Drugs & Biologics Compendium
 - 3) Elsevier Gold Standard's Clinical Pharmacology
 - in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or
 - b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia. Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.
2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.
3. The available scientific evidence must show a good effect on health outcomes outside a research *setting*.

4. The service or supply must be as safe and effective outside a research *setting* as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered *experimental/investigative*.

Clinical trial costs

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your plan may require *you* to use an in-network *provider* to maximize your benefits.

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

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

- i. The investigational item, device, or service, itself; or

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

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Special features and programs

In addition to the health and wellness benefits under *your health plan*, our plans are designed to give *you* services and information to help *you* maintain and improve your health and reach your health potential.

Your health account

You may be offered the opportunity to establish a health account for your health account dollars. If *you* have the opportunity and choose to establish a health account, it will work like a bank account to give *you* control over a portion of the dollars *you* spend on your health.

When *you* establish a health account, the dollars in it are funded by your contributions, including pre-tax payroll deductions and post-tax deposits. Your employer may also choose to make contributions to your health account. *You* can continue to make contributions for as long as *you* remain enrolled in an HSA-compatible health plan. However, once *you* leave an HSA-compatible health plan, *you* can no longer make additional contributions to your health account.

You may use the dollars in your health account to pay for covered services subject to *deductible* and *coinsurance* amounts *you* incur while covered under this health plan. In addition, your health account dollars may be used for any medically qualified services and supplies as defined by the Internal Revenue Service HSA expenditures rules for medical and dental expenses. If health account dollars are used for things other than defined HSA expenditures, there may be tax implications. Please consult your tax advisor for information and advice.

Once established, the health account is totally portable. *You* control the account, and can build up the balance of dollars in the account over time. Any unused health care dollars can be rolled over year after year. If your coverage under this health plan ends for any reason, any balance of unused account dollars remains under your control, until the account is depleted.

Other tools and services

The following programs, tools and services are also included. Although these services are not part of the health and wellness benefits under *your health plan*, they are provided to *you* as a plan participant. Discount services are available through networks administered by other companies - many of which are national leaders in their fields. The discount services listed below are not covered as benefits under *your health plan* and can be discontinued at any time.

24/7 NurseLine

Illness or injury can happen, no matter what time of day. As an *Anthem* health plan member, *you* have access to a team of nurses, available to assist with your questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more, and *you* can call as often as *you* like. Call 866-800-8780.

MyHealth@Anthem®

When *you* visit anthem.com, *you* can access this personalized online resource center. It's full of interactive tools to help *you* assess, manage and improve your health.

AudioHealth Library

For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, there's the AudioHealth Library. It's accessible by phone with more than 400 recorded health topics.

Online Preventive Guidelines

At anthem.com, *you* can use the online preventive guidelines to check on when *you* should have certain check-ups, immunizations, screenings and tests.

Anthem Healthy Solutions Newsletter

Mailed to your home twice a year, this wellness and benefits newsletter can help *you* make wiser decisions about your health and the care *you* need. Packed with practical information, it can help *you* get the most value out of your health care benefits.

SpecialOffers@AnthemSM

With SpecialOffers@Anthem, *you* can access discounts on a wide variety of health and wellness products and services. Find deals on natural health and wellness products; acupuncture, chiropractic and massage therapy; fitness club memberships; weight management; laser vision correction and recommended health and wellness books.

The discount programs and services available through SpecialOffers@Anthem are continually reviewed for opportunities to provide more value to your membership. For the most up-to-date information, always refer to SpecialOffers@Anthem at anthem.com. These discount programs and services are independent of your plan benefits and may change or be cancelled at any time.

Vision Program

To help you care for your eyes, valuable vision discounts are available to you. In order to take advantage of the available discounts, you should seek care from a Blue View Vision participating provider.

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Your Eyewear Discounts

When you visit a Blue View Vision participating eye care professional or vision center, you'll pay the discount price for as many pairs of eyeglasses and/or supplies of conventional (non-disposable) contact lenses selected as you would like.

Your eyewear discounts/costs at participating Blue View Vision provider offices are as follows:

Service	Member Cost*
Frame	35% off retail price
Standard Plastic Lenses	
Single Vision	\$50
Bifocal	\$70
Trifocal	\$105
Lens Options	
UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch-Resistance	\$15
Standard Polycarbonate	\$40
Standard Progressive (Add-on to bifocal)	\$65
Standard Anti-Reflective Coating	\$45
Other Add-ons and Services	20% off retail price
Contact Lenses	
Conventional (non-disposable) - materials only	15% off retail

*Discounts apply towards a complete pair of eyeglasses. If eyeglass materials are purchased separately, a 20% discount is applied.

Plus, Anthem members have access to discounts on laser vision correction surgery and other vision discounts through SpecialOffers@Anthem.

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