CERTIFICATE

Anthem Bronze Pathway X PPO 5150 for HSA

Anthem
P.O. Box 17549
Denver, CO 80217-7549

RIGHT TO EXAMINE

If this Certificate is provided to You as a new Subscriber, then You shall have the right to read the Certificate and any amendments. If the Subscriber is not satisfied for any reason, the Subscriber may notify Us in writing within 10 days of the Effective Date to terminate the insurance coverage. We will refund to the Subscriber all Premiums paid for that 10 day period unless benefits have been paid, in which case We will use the Premium payments to offset benefit payments. We also reserve the right to recover any benefit payments We have made for claims during that 10 day period.

Thank You for selecting Anthem for Your health care coverage. We wish You good health.

DIVISION OF INSURANCE INQUIRIES

For inquiries about health care coverage in Nevada, please call the Division of Insurance within the Department of Business and Industry between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday and ask for the Division of Insurance. The toll free number is (888) 872-3234 and the local numbers are (775) 687-0700 in Carson City and (702) 486-4009 in Las Vegas.

Although the numbers above are designed to assist Members with inquiries and Complaints about health care coverage in Nevada, the Division of Insurance is not equipped to resolve Member Services related inquiries. Please continue to refer these types of inquiries to Anthem Member Services department at 1-855-330-1217. The Member Services phone number is listed on the Subscriber's Identification Card.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

Welcome to Anthem!

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

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

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

Many words used in the Certificate have special meanings (e.g., Covered Services and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Certificate You will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

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

Mike Murphy
President and General Manager
Anthem

How to obtain Language Assistance

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

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

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

Identity Protection Services

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

Contact Us

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

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

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

Anthem
Member Services
P.O. Box 5747
Denver, CO 80217-5747

Visit Us on-line
www.anthem.com

Hours of operation
Monday - Friday
7:30 a.m. to 6:30 p.m. MST

Acceptance of coverage under this Certificate constitutes acceptance of its terms, conditions, limitations and exclusions. Members are bound by all of the terms of this Certificate.

Health benefit coverage is defined in the following documents:

This Certificate, the Schedule of Benefits, and any amendments or endorsements thereto

- The Nevada Individual Enrollment Application for the Subscriber and the Subscriber's Dependents
- Identification Card

We, or anyone acting on Our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner that is consistent with the terms of this Certificate. In the event of any question as to the interpretation of any provision of this Certificate, Our determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, or, in the case of Surgery, cosmetic. However, a Member may utilize all applicable Complaint, Grievance and Appeal procedures available under this Certificate.

This Certificate is not a Medicare Supplement policy. If You as a Member are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Anthem Blue Cross and Blue Shield. Contact Our Member Service department for assistance on how to obtain this information.

Conformity with Law

Conformity with State Statutes: Any provision of this Certificate which, on its Effective Date, is in conflict with the statutes of the State in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Acknowledgement of Understanding

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

Delivery of Documents

We will provide an Identification Card and a Certificate for each Subscriber.

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HIOS ID **33670NV1050001-01**

SCHEDULE OF BENEFITS

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

What will I pay?

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

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

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

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

Plan Features

Deductible	**In-Network Member Pays**	**Out-of-Network Member Pays**
Individual	$5,150	$12,875
Family	$10,300	$25,750

The individual Deductible applies to each covered family Member. No one person can contribute more than their individual Deductible amount.

Once two or more covered family Members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Benefit Period.

Co-insurance	**In-Network Member Pays**	**Out-of-Network Member Pays**
Co-insurance Percentage (unless otherwise specified)	20% Co-insurance	50% Co-insurance

Out-of-Pocket Annual Maximum	In-Network Member Pays	Out-of-Network Member Pays
Individual	$6,550	$16,625
Family Includes Deductible, Copayments and Co-insurance	$13,100	$33,250

The individual Out-of-Pocket Annual Maximum applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Annual Maximum combine to equal the family Out-of-Pocket Annual Maximum amount, the Out-of-Pocket Annual Maximum will be satisfied for the family for that Benefit Period. No one person can contribute more than their individual Out-of-Pocket Annual Maximum.

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

Anthem can help You find an In-Network Provider specific to Your Policy by calling the number on the back of Your Identification Card.

Medical Services

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Ambulance Services		
Emergency (Ground, air and water services) Care is covered In-Network and Out-of-Network. For care from an Out-of-Network Provider, You are responsible for all charges in excess of the Maximum Allowed Amount. Benefits are paid for Medically Necessary ground, air or water ambulance transportation.	$0 Copayment 20% Co-insurance	$0 Copayment 20% Co-insurance plus all charges in excess of the Maximum Allowed Amount.
Non-Emergency Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is Precertified by Us for use. Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute facility to another, must be approved through precertification.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Autism Services Applied Behavior Analysis benefit maximum per Benefit Period: 800 hourly sessions. Benefits are provided to covered Members under 18 years of age or, if enrolled in high school, until the Member reaches 22 years of age. See Outpatient Therapy Services for additional therapy services.	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Pediatric Dental Services are described below.	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Diabetic Medical Equipment & Supplies	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Diagnostic Services; Outpatient		
Diagnostic Laboratory and Pathology Services	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Diagnostic Imaging Services and Electronic Diagnostic Tests	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Advanced Imaging Services	$500 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Doctor Office Visits		
Primary Care Physician (PCP) Office Visits. Retail Health Clinic, includes all Covered Services received at a Retail Health Clinic.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Specialty Care Physician (SCP)	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Inpatient/Outpatient	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Other Office Services Telemedicine	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Durable Medical Equipment (medical supplies and equipment) Includes diabetic supplies and equipment, medical supplies, Durable Medical Equipment, oxygen and equipment, Orthopedic Appliances, prosthetic devices and other appliances. Hearing aids: Limited to a single purchase. Repairs and replacement limited to once every 3 years.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Emergency Room Visits Care is covered In-Network and Out-of-Network. Copayment is waived if admitted.	$500 Copayment 20% Co-insurance	$500 Copayment 20% Co-insurance
Enteral Formula and Special Foods Special food products that are prescribed or ordered by a Physician as Medically Necessary for certain inherited metabolic disorders are allowed.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Home Health Care Limited to a maximum of 30 visits per Member, per Benefit Period combined with Private Duty Nursing Services.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Hospice Care	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Hospital Services		
Inpatient Facility Bariatric Surgery/Gastric Bypass is limited to one surgery every five years. Inpatient Rehabilitation is noted under Inpatient Physical Medicine and Rehabilitation.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Outpatient Facility	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Inpatient and Outpatient Professional Services	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy Services on an Outpatient basis). For more information, refer to Outpatient Therapy Services.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Outpatient Therapy Services Outpatient Habilitative and Rehabilitative Therapy Services (limits on services listed below are not combined but separate based on determination of Habilitative service or Rehabilitative service)		
Chemotherapy, Radiation, and Respiratory	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Physical, Occupational and Speech and Manipulation Therapy		
Physical Therapy – limited to a maximum of 20 visits per Member, per Benefit Period.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Occupational Therapy– limited to a maximum of 20 visits per Member, per Benefit Period.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Speech Therapy– limited to a maximum of 20 visits per Member, per Benefit Period.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Chiropractic Care and Spinal Manipulation Therapy Limited to a combined maximum of 50 visits per Benefit Period.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Cardiac Rehabilitation Limited to a maximum of 36 visits per Member, per Benefit Period, when rendered in the home, Home Health Care limits apply. The program must start within 3 months of the major cardiac event and be completed within 6 months of the major cardiac event.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Preventive Care Services In-Network services required by law are not subject to Deductible. Services include those that meet the requirements of federal and State law including certain screenings, immunizations, all prescribed FDA approved contraceptives and office visits. You can find the current set of preventive benefits at http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/	$0 Copayment 0% Co-insurance	$0 Copayment 50% Co-insurance
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Skilled Nursing Care Copayment is waived if admitted directly to a Skilled Nursing Care Facility from an inpatient Acute Care Facility. Limited to 100 days per Member, per Benefit Period.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Surgery		
Ambulatory Surgical Center	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Temporomandibular & Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Transplant Human Organ & Tissue The following services are covered subject to approval by Anthem: Procurement up to a maximum Anthem payment of $15,000 per transplant. Travel expense up to a maximum Anthem payment of $10,000 per transplant. Daily lodging and meals up to a maximum Anthem payment of $200 per day. **Unrelated Donor Search** $30,000 maximum benefit limit per transplant. See Certificate for details on covered transplants.	$0 Copayment 20% Co-insurance	$0 Copayment 50% Co-insurance
Urgent Care Center Care is covered In-Network and Out-of-Network. For laboratory and pathology services see Diagnostic Services; Outpatient. For x-ray services see Outpatient Diagnostic Tests.	$50 Copayment 20% Co-insurance	$50 Copayment 50% Co-insurance

Prescription Drugs

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

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

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

Retail Pharmacy Prescription Drugs	**In-Network Member Pays**		**Out-of-Network Member Pays**
	Level 1 Pharmacy	**Level 2 Pharmacy**	
Oral chemotherapy drugs are subject to a maximum Deductible, Copayment or Co-insurance, not to exceed $100 per Prescription and/or refill; day supply limits still apply.			
Tier 1	$0 Copayment 20% Co-insurance	$0 Copayment 30% Co-insurance	$0 Copayment 50% Co-insurance
Tier 2	$0 Copayment 20% Co-insurance	$0 Copayment 30% Co-insurance	$0 Copayment 50% Co-insurance
Tier 3	$0 Copayment 40% Co-insurance	$0 Copayment 50% Co-insurance	$0 Copayment 50% Co-insurance
Tier 4	$0 Copayment 40% Co-insurance	$0 Copayment 50% Co-insurance	$0 Copayment 50% Co-insurance

Notes:

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

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider.

Coverage is limited to those Drugs listed on Our Prescription Drug List (Formulary).

Mail Order Prescription Drugs	**In-Network Member Pays**	**Out-of-Network Member Pays**
Tier 1 (90-day supply)	$0 Copayment 20% Co-insurance	Not Covered

Mail Order Prescription Drugs	In-Network Member Pays	Out-of-Network Member Pays
Tier 2 (90-day supply)	$0 Copayment 20% Co-insurance	Not Covered
Tier 3 (90-day supply)	$0 Copayment 40% Co-insurance	Not Covered
Tier 4 (30-day supply)	$0 Copayment 40% Co-insurance	Not Covered

Notes:

Specialty Drugs must be purchased from Anthem's Specialty Preferred Provider and are limited to a 30-day supply.

Coverage is limited to those Drugs listed on Our Prescription Drug List (Formulary).

Pediatric Dental Services

The following pediatric dental services are covered for Members until the end of the month in which they turn 19.

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

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

Pediatric Dental Care	In-Network Member Pays	Out-of-Network Member Pays
Diagnostic and Preventive Services	Deductible does not apply; 0% Co-insurance	Deductible does not apply; 30% Co-insurance
Basic Restorative Services	40% Co-insurance	50% Co-insurance
Oral Surgery Services	50% Co-insurance	50% Co-insurance
Endodontic Services	50% Co-insurance	50% Co-insurance
Periodontal Services	50% Co-insurance	50% Co-insurance
Major Restorative Services	50% Co-insurance	50% Co-insurance
Prosthodontic Services	50% Co-insurance	50% Co-insurance
Dentally Necessary Orthodontic Care Services	50% Co-insurance	50% Co-insurance

Pediatric Vision Services

The following vision care services are covered for Members until the end of the month in which they turn 19. To get the In-Network benefit You must use a Blue View Vision Provider. Visit Our website or call Us at the number on Your ID card if You need help finding a Blue View Vision Provider.

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

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

Covered Vision Services	In-Network Member Pays	Out-of-Network Reimbursement
Routine Eye Exam Covered once per calendar Year per Member	$0 Copayment	Up to $30
Standard Plastic or Glass Lenses One set of lenses covered per calendar Year per Member.		
Single Vision	$0 Copayment	Up to $25
Bifocal	$0 Copayment	Up to $40
Trifocal	$0 Copayment	Up to $55
Progressive	$0 Copayment	Up to $40
Lenticular	$0 Copayment	Up to $70
Additional Lens Options Covered lenses include the following lens options at no additional cost when received In-Network: factory scratch coating, UV coating, standard polycarbonate, standard photochromic, gradient tinting, oversized and glass-grey #3 prescription sunglasses.		
Frames (formulary) One frame covered per calendar Year per Member.	$0 Copayment	Up to $45
Contact Lenses (formulary) Elective or non-elective contact lenses are covered once per calendar Year per Member.		
Elective (conventional and disposable)	$0 Copayment	Up to $60
Non-Elective	$0 Copayment	Up to $210
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next Benefit Period.		
Low Vision		

Covered Vision Services	In-Network Member Pays	Out-of-Network Reimbursement
Low vision benefits are only available when received from Blue View Vision providers.		
Comprehensive Low Vision Exam Covered once per calendar Year per Member.	$0 Copayment	Not Covered
Optical/non-optical aids and supplemental testing. Limited to one occurrence of either optical/non-optical aids or supplemental testing per calendar Year per Member.	$0 Copayment	Not Covered

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

HOW YOUR COVERAGE WORKS

Your plan is a PPO plan. The plan has two sets of benefits: In-Network and Out-of-Network. If You choose an In-Network Provider, You will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Co-insurance. If You use an Out-of-Network Provider, You will have to pay more out-of-pocket costs.

If You need to see a Specialist who is within Your Service Area, You can visit any In-Network Specialist including a behavioral health Provider, without a referral. If You need to see a Specialist who is not within Your Service Area, please contact Your PCP to get a referral. But remember, even when a service does not require a referral, or even when You have a referral from Your PCP, some services will still require an authorization. For more information about authorizations, please see the "Requesting Approval for Benefits" later in this section. For more information about the plan's Service Area, please see the "Schedule of Benefits."

In-Network Services

When You use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with Us to care for You. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

Primary Care Physicians / Providers (PCP)

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

Referrals are not needed to visit an In-Network Specialist, including behavioral health Providers, within your Service Area. If you need to see a Specialist who is outside of your Service Area, please contact your PCP to get a referral. But remember, even when a service does not require a referral, or even when you have a referral from a PCP, some services will still require an authorization.

To see a Doctor, call their office:

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

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

For services from In-Network Providers:

1) You will not need to file claims. In-Network Providers will file claims for Covered Services for You. (You will still need to pay any Co-insurance, Copayments, and/or Deductibles that apply.) You may be billed by Your In-Network Provider(s) for any non-Covered Services You get or when You have not followed the terms of this Certificate.
2) Precertification will be done by the In-Network Provider.

We do not guarantee that an In-Network Provider is available for all services and supplies covered under Your PPO plan. For some services and supplies We may not have arrangements with In-Network Providers.

Out-of-Network Services

When You do not use an In-Network Provider, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Certificate.

For services from an Out-of-Network Provider:

1) In addition to any Deductible and/or Co-insurance/Copayments, the Out-of-Network Provider can charge You the difference between their bill and the plan's Maximum Allowed Amount;
2) You may have higher Cost Sharing amounts (i.e., Deductibles, Co-insurance, and/or Copayments);
3) You will have to pay for services that are not Medically Necessary;
4) You will have to pay for non-Covered Services;
5) You may have to file claims; and
6) You must make sure any necessary Precertification is done.

We will not deny or restrict Covered Services just because You get treatment from an Out-of-Network Provider; however, You may have to pay more.

We pay the benefits of this Certificate directly to Out-of-Network Providers, if You have authorized an assignment of benefits. An assignment of benefits means You want Us to pay the Provider instead of You. We may require a copy of the assignment of benefits for Our records. These payments fulfill Our obligation to You for those services.

How to Find a Provider in the Network

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

- Go to the directory of In-Network Providers at www.anthem.com. Here You can find lists of Doctors, Providers, and Facilities that participate in Our network.
- Call Member Services to ask for a list of Doctors and Providers that participate in Our network, based on specialty and geographic area.
- Check with Your Doctor or Provider.

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

Visiting a Provider in the Network

In-Network Providers include Primary Care Physicians/Providers (PCP's), Specialists (Specialty Care Physicians/Providers (SCP's), other Professional Providers, Hospitals, and other facilities who contract with Us to care for You. Referrals are never needed to visit an In-Network Specialist including behavioral health Providers. You do not need a referral from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who specializes in obstetrics or gynecology.

To see a Physician, call their office:

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

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

Dental Providers

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

Please call our Member Services department at (800) 627-0004 for help in finding an In-Network dentist or visit Our website at www.anthem.com/mydentalvision. Please refer to Your Identification Card for the name of the dental program that In-Network Providers have agreed to service when You are choosing an In-Network dentist.

Identification Card

When You get care, You must show Your Identification Card. Only a Member who has paid the Premium for this coverage has the right to services or benefits under this Certificate. If anyone gets services or benefits which they are not allowed to receive under the terms of this Certificate, he/she must pay for the cost of the services.

REQUESTING APPROVAL FOR BENEFITS

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

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

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

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

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

Types of Reviews

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

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

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

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

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

Who is Responsible for Precertification

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

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

How Decisions are Made

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

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

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

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

Decision and Notice Requirements

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

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Concurrent/Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Urgent Concurrent/Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Concurrent/Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Concurrent/Continued Stay Review	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

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

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

Important Information

We may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) and/or offer

an alternative benefit if, in Our discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

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

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

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

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 plan's Members.

Health Plan Individual Case Management

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

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

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

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

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this plan. We will make Our 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 case, We will notify You or Your representative in writing.

WHAT IS COVERED

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

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

- "Schedule of Benefits" – for amounts You need to pay and benefit limits

- “Requesting Approval for Benefits” – for details on selecting providers and services that require pre-authorization
- “What is Not Covered (Exclusions)” – for details on services that are not covered

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

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

Medical Services

Ambulance Services (Air, Ground and Water)

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

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

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

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

Out-of-Network Providers may bill You for any charges that exceed the plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to medical necessity review by Us.

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

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by Us. We retain the right to select the air Ambulance Provider. This includes fixed wing, rotary wing or water transportation.

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

Hospital to Hospital Air Ambulance Transport

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

Fixed and Rotary Wing Air Ambulance

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

Autism Services

This section describes Covered Services and exclusions for the screening, diagnosis and treatment of autism spectrum disorder. Autism Spectrum Disorder is a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified. Coverage provided under this section is subject to the same cost-sharing provisions as other like medical services or Prescription Drugs are covered by this Certificate. Coverage is provided for the screening, diagnosis, and treatment of autism spectrum disorder to Members under 18 years of age or, if enrolled in high school, until the Member reaches 22 years of age. Covered Services are allowed up to the maximum visits as listed on the "Schedule of Benefits" per Member's Benefit Period.

Screening for Autism Spectrum Disorders means Medically Necessary assessments, evaluations or tests to screen and diagnose whether a Member has an autism spectrum disorder.

Treatment of Autism Spectrum Disorders must be identified in a treatment plan and may include Medically Necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

- Prescribed for a Member diagnosed with an Autism Spectrum Disorder by a licensed Physician or licensed psychologist; and
- Provided for a Member diagnosed with an autism spectrum disorder by a licensed Physician, licensed psychologist, licensed behavior analyst or other Provider that is supervised by the licensed Physician, psychologist or behavior analyst.

Solely as used in this Autism Spectrum Disorders section, the following terms and definitions will apply:

- Applied behavior analysis – the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior. Benefits for applied behavior analysis treatment are limited to a maximum benefit as listed on the "Schedule of Benefits".
- Behavior or Behavioral therapy – any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or Registered Behavior Technician.
- Evidence-based research – research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to Autism Spectrum Disorders.
- Habilitative or rehabilitative care – counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.
- Licensed assistant behavior analyst – a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.
- Licensed behavior analyst – a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.
- Prescription care – medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.
- Psychiatric care – direct or consultative services provided by a psychiatrist licensed in the State in which the psychiatrist practices.
- Psychological care – direct or consultative services provided by a psychologist licensed in the State in which the psychologist practices.

- Registered Behavior Technician – a person who is Registered Behavior Technician or an equivalent by the Behavior Analyst Certification Board, Inc., and provides behavioral therapy under the supervision of a:
  1) licensed psychologist;
  2) licensed behavior analyst; or
  3) licensed assistant behavior analyst.
- Therapeutic care – services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.
- Treatment plan – a plan to treat an Autism Spectrum Disorder that is prescribed by a licensed Physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

  We may request a copy of and review the autism spectrum treatment plan. Services for Autism Spectrum Disorder may be subject to Preauthorization and Utilization Management - see the "Requesting Approval For Benefits" section for more information.

Services for Autism Spectrum Disorders are subject to the same general exclusions or limitations as other medical services or Prescription Drugs covered by this Certificate. See the "What Is Not Covered" section of this Certificate.

Bariatric Surgery

Bariatric Surgery and complications from bariatric Surgery that satisfy Our medical policy are covered.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs given to You as a participant in an approved Clinical Trial if the services are Covered Services under this plan. An "approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. It also includes a Phase II, Phase III or Phase IV study or Clinical Trial for the treatment of chronic fatigue syndrome. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated, including, but not limited to, chronic fatigue syndrome.

Benefits are limited to the following trials:

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

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.
4. Before participating in an Approved Clinical Trial, the Member has signed a statement of consent indicating that they have been informed of, without limitation: (a) the procedure to be undertaken; (b) alternative methods of treatment; and (c) the risks associated with participation in the Approved Clinical Trial or, including, without limitation, the general nature and extent of such risks.

We may require You to use an In-Network Provider to maximize Your benefits.

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

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

Dental Related Services

This section describes Covered Services for accident related Dental Services, Anesthesia for children, inpatient services for dental related services, and temporomandibular joint care. **This Dental Related Services section provides coverage for health conditions and should not be considered as the Member's dental coverage.** All Dental Services and supplies are subject to Preauthorization guidelines. See the section "Requesting Approval for Benefits" for information on Preauthorization guidelines.

Dental Anesthesia

Benefits are provided for general Anesthesia when provided in a Hospital, outpatient surgical facility or other facility, and for associated Home Health Services or facility charges for dental care is provided to a covered Dependent child who:

- has a physical, mental or medically compromising condition;
- has dental needs for which local Anesthesia is not effective because of acute infection, an anatomic anomaly or allergy;
- is extremely uncooperative, unmanageable, or anxious; or
- has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

Dental service related to an accident

Benefits are provided for accident-related dental expenses when the Member meets all of the following criteria:

- Dental Services, supplies and appliances are needed because of an accident in which the Member sustained other significant bodily injuries outside the mouth or oral cavity.
- Treatment must be for injuries to Your sound natural teeth.
- Treatment must be necessary to restore Your teeth to the condition they were in immediately before the accident.
- The first Dental Services must be performed within 90 days after Your accident.
- Related services must be performed within one year after Your accident. Services after one year are not covered even if coverage is still in effect.

Benefits for restorations are limited to those services, supplies, and appliances We determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident.

Inpatient Admission for Dental Care

Benefits are provided for inpatient facility services including room and board, but do not include charges for the Dental Services, only if the Member has a non-dental related physical condition, such as a bleeding disorder or heart condition that make the hospitalization Medically Necessary.

Other Dental Conditions

Benefits are provided in connection with conditions of the mouth (excluding teeth and gums) arising from disease, trauma, injury, or Congenital Defect, if determined to be Medically Necessary.

Diabetic Management

Benefits are provided to Members who have insulin dependent Diabetes, non-insulin dependent Diabetes and elevated blood glucose levels induced by pregnancy or other medical conditions when Medically Necessary.

Benefits are provided for Diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams. Training and education are covered throughout the Member's disease course when provided by a certified, registered, or licensed health care professional with expertise in Diabetes. Insulin pumps and related supplies are covered subject to meeting Our medical policy criteria. Replacement of pumps that are out of warranty and are malfunctioning and cannot be refurbished would be a covered service. In situations where new models or upgrades to the latest insulin pump are requested, coverage would not be available.

When Diabetic supplies are provided by a Pharmacy they are covered under the benefits for Prescription Drugs. Please refer to Your "Schedule of Benefits" for cost sharing information. Screenings for gestational diabetes are covered under "Preventive Care Services".

Diabetic Management Exclusions

Diabetic supplies and equipment are not covered when received from an Out-of-Network Provider.

Diagnostic Services Outpatient

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

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Doctor (Physician) Visits

Covered Services include:

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

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

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

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

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

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

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

Telehealth Services is the real-time transfer of health data and help to a patient at a different location. Services are available when provided by covered providers at a Distant Site. Services include the use of interactive audio, video, or other electronic media to discuss and treat the Member's health problem when the Member is receiving services at an Originating Site. These services are covered as if they would be Covered Services when given in a face-to-face meeting with the Provider. There are limits.

Non-Covered Services for Telehealth also include, but are not limited to:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals;
- Benefit Precertification;
- Doctor talking to another Doctor; and
- Phone, fax, or email communications between a Provider and Member for telemedicine.

Telehealth benefits include coverage for services to treat a Member through Telehealth to the same extent as though provided in person. However, We may not:

- Require a Member to establish a relationship in person with a Provider of health care or provide any additional consent to or reason for obtaining services through Telehealth as a condition to providing coverage;
- Require Covered Services to be provided through Telehealth as a condition to providing coverage for such services.

Emergency Care Services

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

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

Emergency (Emergency Medical Condition)

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

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

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

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

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

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

Habilitative Services

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

Home Care Services

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

Covered Services include but are not limited to:

- Visits by a licensed health care professional, including nursing services by an R.N. or L.P.N., a therapist, or home health aide.
- Infusion Therapy; refer to Other Therapy Services, later in this section for more information

- Medical/social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving Skilled Nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Medical supplies
- Durable medical equipment
- Therapy Services
- Private duty nursing in the home

Preauthorization is required for Home Care Services.

Hospice Care

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

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

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care. Inpatient respite care may be limited to a maximum of five consecutive days per admission.
- Skilled nursing services and home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, Occupational therapy, Speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies.
- Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the member's death. Bereavement services are available to surviving covered family members.
- Bereavement support services for the covered family members during the twelve-month period following the death of the Member.

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

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

Hospital Services

Inpatient Hospital Care

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

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

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Treatment for a health problem by a Doctor who is not Your surgeon while You are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by Your Doctor. Benefits are not available for staff Consultations required by the Hospital, Consultations asked for by the patient, routine Consultations, phone Consultations, or EKG transmittals by phone.
- Surgery and general Anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Outpatient Hospital Care

Your Certificate includes Covered Services in an:

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

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

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

Maternity and Reproductive Health Services

Maternity Services

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

Covered maternity services include:

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

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

Contraceptive Benefits

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

Sterilization Services

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

Abortion Services

Benefits for abortions in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).

Infertility

Infertility benefits include the following Covered Services:

Limited diagnostic and therapeutic infertility services determined to be Medically Necessary and Preauthorized by Us. Covered Services do not include those services specifically excluded herein, but do include limited:

- Laboratory studies.
- Diagnostic procedures; and
- Artificial insemination services, up to 6 cycles per Member per lifetime.

Medical Supplies, Durable Medical Equipment and Appliances

Durable Medical Equipment and Medical Devices

Your Certificate includes benefits for Durable Medical Equipment and medical devices when the equipment meets the following criteria:

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

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and

continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by Us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

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

Oxygen and equipment for its administration are also Covered Services.

Hearing Supplies

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

- Hearing Aids – Any wearable, non-disposable instrument or device designed to aid or compensate for impaired human hearing.

Orthotics

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

Prosthetics

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

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

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

Medical and Surgical Supplies

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

Diabetic Equipment and Supplies

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

Blood and Blood Products

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

Food and Nutrition

This section describes Covered Services and exclusions for nutrition therapy. Benefits for enteral therapy and Total Parenteral Nutrition (TPN) include a combination of nursing, Durable Medical Equipment and

pharmaceutical services. An In-Network licensed therapist or Home Health Agency must provide the nutrition services. All services must be preauthorized, see the "Requesting Approval for Benefits" section for information on Preauthorization guidelines.

Enteral therapy and Total Parenteral Nutrition

Enteral therapy is delivery of nutrients by a tube into the gastrointestinal tract. Total Parenteral Nutrition (TPN) is the delivery of nutrients through an intravenous line directly into the bloodstream.

Nursing visits to assist with enteral nutrition are covered under the home health benefits when Medically Necessary and is not considered Custodial Care. These services are frequently provided through a Home Health Agency. More information can be found under the heading "Home Care Services" and "Hospice Care".

Benefits are provided for use at home for enteral formulas that are prescribed or ordered by a Physician for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from Congenital Defect or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat metabolism. Special food products that are prescribed or ordered by a Physician as Medically Necessary are allowed. Coverage is provided whether or not the condition existed when coverage began under this Certificate.

TPN received in the home is a covered benefit when it is determined to be Medically Necessary.

Mental Health and Substance Abuse Services

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

Covered Services include the following:

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

You can get Covered Services from the following Providers:

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

Preventive Care Services

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

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
    - Breast cancer,
    - Cervical cancer,
    - High blood pressure,
    - Type 2 Diabetes Mellitus,
    - Cholesterol,
    - Child or adult obesity,
    - Colorectal cancer.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive Care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - Contraceptive coverage includes generic drugs and single-source brand name drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source brand name drugs will be covered, as preventive care benefits when medically necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail order) Pharmacy".
    - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per calendar year or as required by law.
    - Gestational diabetes screening.
5. Preventive Care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
    - Counseling
    - Prescription Drugs
    - Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.
    - Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
    - Aspirin
    - Folic acid supplement
    - Vitamin D supplement
    - Bowel preparations

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

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

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

Rehabilitative Services

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

Skilled Nursing Facility

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

Surgery

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

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

Oral Surgery

Although this Certificate 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;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part;
- Oral/surgical correction of accidental injuries;
- 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.

Reconstructive Surgery

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

Note: This section does not apply to orthognathic surgery.

Mastectomy Notice

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

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and

- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services Outpatient

Physical Medicine Therapy Services

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

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

Other Therapy Services

Benefits are also available for:

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

- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Chiropractic Services** – Chiropractic benefits are allowed for services administered by a chiropractor who acts within the scope of their license for the chiropractic treatment of an illness or Accidental Injury. Chiropractic benefits are limited to office visits for manual manipulation of the spine, X-ray of the spine and certain physical modalities and procedures. Please refer to Your "Schedule of Benefits" for visit limits.

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

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

Covered Transplant Procedure

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

Unrelated Donor Searches

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

Live Donor Health Services

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

Transplant Benefit Period

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

Preauthorization and Precertification

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

Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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

Transportation and Lodging

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

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

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

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

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member Cost-Shares.

Urgent Care Services

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

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

Prescription Drugs

Prescription Drugs Administered by a Medical Provider

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

Important Details About Prescription Drug Coverage

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

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

- quantity, dose, and frequency of administration;
- specific clinical criteria (including but not limited to requirements regarding age, test result requirements, and/or presence of a specific condition or disease;)
- specific provider qualifications (including but not limited to REMS certification (Risk, Evaluation and Mitigation Strategies));
- step therapy requiring one drug or a drug regimen or another treatment be used prior to use of another drug or drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another;
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.)

Precertification

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

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

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

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

Designated Pharmacy Provider

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

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

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

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

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

Therapeutic Substitution

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

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

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

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

Prescription Drug Benefits

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

Prior Authorization

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

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

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

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

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

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

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

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration).
- Prescription Drugs used to treat infertility.

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, Co-insurance, and/or Deductible that applies when You get the Drug. If You do not have Your Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Note: If We determine that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of In-Network Pharmacies may be limited. If this happens, We may require You to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if You use the single In-Network Pharmacy. We will contact You if We determine that use of a single In-Network Pharmacy is needed and give You options as to which In-Network Pharmacy You may use. If You do not select one of the In-Network Pharmacies We offer within 31 days, We will select a single In-Network Pharmacy for You. If You disagree with Our decision, You

may ask us to reconsider it as outlined in the "If You have a Complaint or an Appeal" section of this Certificate.

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

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

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

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

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. We may require You or Your Doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

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

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

When You Order Your Prescription Through the Specialty Preferred Provider

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

Specialty Pharmacy Program

If You are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next

business day following a holiday or weekend to allow You to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your Doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Co-insurance, if any.

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

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets You get certain Drugs by mail if You take them on a regular basis (Maintenance Medication). You will need to contact the PBM to sign up when You first use the service. You can mail written prescriptions from Your Doctor or have Your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Co-insurance amounts that apply when You ask for a prescription or refill.

Maintenance Medication

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

Home Delivery Pharmacy

If You are taking a Maintenance Medication, You may get the first 30 day supply and one 30 day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication You get without registering Your choice each year through the Home Delivery Pharmacy. You can tell us Your choice by phone at 1-888-772-5188 or by visiting Our website at www.anthem.com.

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

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

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

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

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

What You Pay for Prescription Drugs

Tiers

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

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

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

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

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

Prescription Drug List

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

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

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

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

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

Exception Request for a Drug not on the Prescription Drug List

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

request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of Your prescription, including refills.

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

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

Drug Utilization Review

If there are patterns of over utilization or misuse of Drugs, We will notify Your personal Physician and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of 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. Early refills may also be available for Topical Ophthalmic Products and for synchronizing Chronic Medications, as required by law. We may also authorize coverage for less than a 30-day supply for purposes of synchronizing medications. We will work with the Pharmacy to decide when this should happen. As used in this section, Chronic Medication means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely, or as defined by Nevada law. Topical Ophthalmic Product means a liquid prescription drug which is applied directly to the eye from a bottle or by means of a dropper, or as defined by Nevada law.

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 Services at the number on the back of Your Identification Card.

Half-Tablet Program

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

Therapeutic Substitution

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

Split Fill Dispensing Program

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

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

Special Programs

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

Pediatric Dental Care

Your Dental Benefits. Dental care treatment decisions are made by You and Your dentist. We cover treatment based on what benefits You have, not whether the care is medically or dentally necessary. The only exception is when You get orthodontic care - We do review those services to make sure they're appropriate.

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

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

Pediatric Dental Essential Health Benefits. The following dental care services are covered for members until the end of the month in which they turn 19. All covered services are subject to the terms, limitations, and exclusions of this Certificate. See the "Schedule of Benefits" for any applicable Deductible, Co-insurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

Oral Exams. Two oral exams are covered every 12 months.

Radiographs (X-rays)

- Bitewings – 2 sets per 12 months.
- Full mouth (also called complete series) or panoramic.
- Periapicals, occlusals and extraoral films are also covered.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per 12 months. Paid as child prophylaxis if Member is 13 or younger, and adult prophylaxis starting at age 14.

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

Sealants. Covered once per tooth per lifetime. Covered for permanent molars only.

Space Maintainers.

Basic Restorative Services

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

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

Pre-fabricated or Stainless Steel Crown.

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

Partial pulpotomy for apexogenesis. Covered on permanent teeth only.

Endodontic Services

Endodontic Therapy. The following will be covered for permanent teeth only:

- Root canal therapy.
- Root canal retreatment.

Endodontic Therapy. The following will be covered for primary teeth only.

- Pulpal therapy.
- Therapeutic pulpotomy.

Periodontal Services

Full Mouth Debridement. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth.

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

- Gingivectomy/gingivoplasty
- Anatomical crown exposure
- Gingival flap
- Osseous surgery
- Bone replacement graft
- Pedicle soft tissue graft
- Free soft tissue graft
- Subepithelial connective tissue graft
- Distal/proximal wedge. Covered on natural teeth only.

Periodontal Maintenance. This procedure includes periodontal evaluation, removing bacteria from the gum pocket areas, measuring the gum pocket areas, and scaling and polishing of the teeth. Covered for Members that have completed previous surgical or nonsurgical periodontal treatment.

Periodontal Scaling and Root Planing. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth.

Provisional Splinting

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered only when given with a covered complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist that is certified in their profession to give anesthesia services.

Oral Surgery Services

Basic Extractions

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

Complex Surgical Extractions. Surgical removal of 3rd molars are covered only when symptoms of oral pathology exists.

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

Major Restorative Services

Gold foil restorations. Gold foil restorations are covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same Maximum Allowed Amount for an amalgam filling. You're responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Co-insurance.

Inlays. Inlays are covered at the same frequency as an amalgam filling. Inlays will be paid up to the same Maximum Allowed Amount for an amalgam filling. You're responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Co-insurance.

Permanent Crowns. Covered 1 time per tooth per lifetime. Only covered on a permanent tooth. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. If You choose to have another type of crown, You're responsible to pay for the difference plus any applicable Deductible and Co-insurance.

Recement an Onlay or Crown.

Crown Repair.

Core Build Up. Includes any pins.

Prefabricated Post and Core (in addition to crown).

Prefabricated or Stainless Steel Crowns.

Sedative Filling.

Pin Retention. Per tooth, in addition to restoration.

Prosthodontic Services

Dentures and Partials (removable prosthodontic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If You have an existing denture or partial, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted.

Bridges (fixed prosthodontic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If You have an existing bridge, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted. In order for the bridge to be covered:

- A natural healthy and sound tooth is present to serve as the anterior and posterior retainer.
- There are no other missing teeth in the same arch that have been replaced with a removable partial denture.
- And none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this plan in the last 60 months.

The plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the plan may cover a partial denture instead of the bridge. If You still choose to get the bridge, You will be responsible to pay the difference in cost, plus any applicable Deductible and Co-insurance.

Reline and Rebase. Covered 1 time per 36 months as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance.

Orthodontic Care

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

Dentally Necessary Orthodontic Care. This plan will only cover orthodontic care that is dentally necessary - at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with Your biting function.
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of Your mouth when You bite.
- The position of Your jaw or teeth impairs Your ability to bite or chew.

- On an objective, professional orthodontic severity index, Your condition scores consistent with needing orthodontic care.

What Orthodontic Care Includes. Orthodontic care may include the following types of treatment:

- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office visits.
- Removable Appliance Therapy. Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy. Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

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

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

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

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

- Monthly treatment visits that are billed separately - these costs should already be included in the cost of treatment.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately - these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this Certificate.

Pediatric Vision Care

These vision care services are covered for Members until the end of the month in which they turn 19. To get In-Network benefits, use a Blue View Vision eye care Provider. For help finding one, try "Find a Doctor" on Our website, or call Us at the number on Your ID card. See the Schedule of Benefits to see Your Deductible, Co-insurance, Copayment and benefit limitations.

Routine Eye Exam

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

Eyeglass Lenses

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

There are a number of additional covered lens options that are available through Your Blue View Vision Provider. See the "Schedule of Benefits" for the list of covered lens options.

Frames

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

Contact Lenses

Each Year, You get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options in a given Year. Your Blue View Vision Provider will have a collection of contact lenses for You to choose from. They can tell You which contacts are included at no extra charge - and which ones will cost You more.

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

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

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses;
- High ametropia exceeding -12D or +9D in spherical equivalent
- Pathological myopia, aphakia, anisometropia (of 3D or more), aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism
- For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses
- If contact lenses result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

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

Low Vision

Low vision is when You have a significant loss of vision, but not total blindness. Your plan covers services for this condition when You go to a Blue View Vision eye care Provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

WHAT IS NOT COVERED (EXCLUSIONS)

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

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

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

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

Medical Services

Your Medical benefits do not cover:

Abortion. We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed.

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

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

- IgE RAST tests unless intradermal tests are contraindicated.
- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
- Food allergy test panels (including SAGE food allergy panels).
- Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Antigen leukocyte cellular antibody test (ALCAT); or
- Cytotoxic test; or
- HEMOCODE Food Tolerance System; or
- IgG food sensitivity test; or
- Immuno Blood Print test; or
- Leukocyte histamine release test (LHRT).

Alternative/Complementary Medicine. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

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

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

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

Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the "What is Covered" section unless otherwise required by law.

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

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

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

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

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

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

Cochlear Implants. For cochlear implants. Except as specified in the "What is Covered" section of this Certificate.

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

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

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

Cosmetic Services. Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-

funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

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

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

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

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

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

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Implants. For Dental implants unless specifically stated as a Covered Service.

Dental Treatment. For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Certificate. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:

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

Dental X-Rays, Supplies & Appliances. For Dental x-rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service. The only exceptions to this are for any of the following:

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

Drugs Prescribed by Providers lacking qualifications/certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications as determined by Us.

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.

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.)

Education/Training. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

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

- Follow-up care received in an Emergency department or Urgent Care center, including but not limited to, removal of stitches and dressing changes.
- Maternity care and/or deliveries outside the Service Area within five weeks of the anticipated delivery date, except in an Emergency.
- Non-Emergency continued care after the Member's condition has stabilized.

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

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

Eyeglasses/Contact Lenses. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular Surgery, or for soft contact lenses due to a medical condition.

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

Birth Control.

- Over the counter products for birth control purpose (e.g., sponges, spermicides and condoms).
- Reversals of voluntarily induced sterility.

Infertility.

- Services when the obstruction is related to the reversal of a surgical sterilization.
- Hormonal manipulation and excess hormones to increase production of mature ova for fertilization.
- Any service, supply or drug used in conjunction with or for the purpose of an artificially induced pregnancy including Artificial Reproductive Technology (ART).
- Test tube fertilization, drugs for induced ovulation or other artificial methods of conception.
- Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT) and any related services.
- Cost of donor sperm or donor eggs.
- Diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy.
- Storage costs for sperm or frozen embryos.
- Home pregnancy or ovulation tests.
- Sonohysterography.
- Monitoring of ovarian response to stimulants.
- CT or MRI of sella turcica unless elevated prolactin level.
- Evaluation for sterilization reversal.
- Laparoscopy.
- Ovarian wedge resection.
- Removal of fibroids, uterine septae and polyps.

- Open or laparoscopic resection, fulguration, or removal of endometrial implants.
- Surgical lysis of adhesions.
- Surgical tube reconstruction.

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

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

Food and Nutrition. For services, supplies or care for:

- Enteral feedings except as stated in the "What is Covered" section
- Tube feeding formula except as stated in the "What is Covered" section
- Food, meals, formulas, and supplements other than those listed, even if the food, meal, formula or supplement is the sole source of nutrition, except as stated in the "What is Covered" section
- Breast feeding education, see the "What is Covered" section for coverage of breast feeding support
- Baby formulas.
- Feeding clinics

Foot Care – Routine. For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:

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

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

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

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

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

Hospice Care. We do not provide benefits for the following services, supplies or care:

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

Human Growth Hormone. Human Growth Hormone.

Hyperhydrosis. For treatment of hyperhydrosis (excessive sweating).

Impotency. Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription

Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. This exclusion shall not apply to services or supplies which are specifically covered in this Certificate, are authorized by Us, or must be covered under applicable law or regulation.

Incarceration. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Infertility Testing and Treatment. Covered services do not include assisted reproductive technologies (ART) or the diagnostic tests and drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT) or gamete intrafallopian transfer (GIFT).

Maintenance Therapy. For maintenance therapy which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

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

Missed/Cancelled Appointments. For missed or cancelled appointments.

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

Non Authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

Non-duplication of Medicare. Benefits will not be provided that duplicate any benefits You would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which You enroll without paying additional Premium. However, if You have to pay an additional Premium to enroll in Part A, B, or C or D of Medicare, this exclusion will apply to the particular Part(s) of Medicare for which You must pay only if You have enrolled in the Part(s).

Non Emergency Care Received in Emergency Room. For care received in an Emergency Room that is not Emergency Care, except as specified in the "What is Covered" section. This includes, but is not limited to, suture removal in an Emergency Room.

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

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

Office Visits and Doctor Services. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Expenses for obtaining medical reports or transfer of files.
- Treatment for hair loss, even if caused by a medical condition, except for alopecia areata.
- Routine foot care such as care for corns, toenails or calluses except for Members with diabetes.
- Telephone or Internet Consultations, except where online visit services are specifically covered as a Physician Office service.
- Treatment for sexual dysfunction.
- Genetic counseling.
- Separate reimbursement for Anesthesia and post-operative care when services are provided by the same Physician in the Physician's office.

- Peripheral Bone Density Scans.
- Online visit do not include reporting normal lab or other test results, office appointment requests, billing, insurance coverage or payment questions, requests for referrals to Doctors outside the online care panel, benefit precertification, and Physician to Physician Consultation.

Off label use. Off label use, unless We must cover the use by law or if We approve it.

Other Medical/Dental Coverage. If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:

- the part of any Charge that is more than the other coverage's benefit or
- the benefit We would pay if You had no other coverage.

Other medical or dental expense coverage includes, but is not limited to:

- individual or family plan health insurance;
- group health insurance
- automobile insurance

Outdoor Treatment Programs and/or Wilderness Programs.

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

Personal Hygiene, Environmental Control or Convenience Items. For personal hygiene, environmental control, or convenience items including but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

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

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

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

- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member, except as provided in the "What is Covered" section.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges that are not documented in Provider records.

- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, Orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

Private Duty Nursing. For Private Duty Nursing Services unless specified in the "What is Covered" section.

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

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

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

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

Residential Accommodations to treat behavioral health conditions, except when provided in a Hospital or Residential Treatment Center.

Reversal of Sterilization. For reversal of sterilization.

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

Self-Help Training/Care. For self-help training and other forms of non-medical self care, except as otherwise provided herein.

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

Spinal Decompression Devices. Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

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

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

Teeth, Jawbone, Gums. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

Telephone/Internet Consultations. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

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

- Gastric electrical stimulation
- Hippotherapy
- Intestinal rehabilitation therapy
- Prolotherapy

- Recreational therapy
- Sensory integration therapy (SIT)

Therapies - Outpatient. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Home programs for on-going conditioning and maintenance.
- Therapies for learning disorders, behavioral or personality disorders. Therapies (including but not limited to Speech Therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, stuttering, voice or rhythm disorders.
- Benefits are not covered for non-specific diagnoses relating to learning-related disorders.
- Therapeutic exercise equipment prescribed for home use such as treadmills and/or weights.
- Convenience items as determined by Us.
- The purchase of pools, whirlpools, spas and personal hydrotherapy devices.
- Services related to worker's compensation injuries.
- Therapies and self-help programs not specifically identified as a Covered Service.
- Recreational, sex, primal scream, sleep and Z therapies.
- Biofeedback.
- Rebirthing therapy.
- Self-help, stress management and weight loss programs.
- Smoking cessation programs. This does not include services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) which is explained in the "What is Covered" section of this Certificate.
- Transactional analysis, encounter groups and transcendental meditation (TM).
- Sensitivity training, anger management or assertiveness training.
- Rolfing, pilates, Myotherapy or prolotherapy.
- Holistic Medicine and other wellness programs.
- Educational programs such as behavior modification or arthritis classes are not covered, except as otherwise specifically provided herein.
- Services for sensory integration disorder.
- Occupational therapies for diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts).
- Acupuncture care except as provided herein.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Exclusions. Non-Covered Services for transportation and lodging include, but are not limited to:

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

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

Vision Orthoptic Training. For vision orthoptic training. This exclusion does not apply to Members through the end of the month in which the Member turns age 19.

Waived Copayment, Co-insurance, or Deductible. For any service for which You are responsible under the terms of this Certificate to pay a Copayment, Co-insurance, or Deductible and the Copayment, Co-insurance or Deductible is waived by an Out-of-Network Provider.

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

Workers Compensation. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment, except as specifically covered in this Certificate.

Prescription Drugs

Your Prescription Drug benefits do not cover:

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

the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.

- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.
- Gene Therapy as well as any Drugs, procedures, health care services related to it that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
- Services or Supplies from Family Members. Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, Domestic Partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

Pediatric Dental Care

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

- Dental Care for Members age 19 and older, unless covered by the medical benefits of this Certificate.
- Dental services or health care services not specifically covered under the Certificate (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this Certificate).
- Services of anesthesiologist, unless required by law.
- Anesthesia Services, (such as intravenous or non-intravenous conscious sedation, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case presentations, office visits, consultations.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the policy.
- Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this policy.
- Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this policy.
- Separate services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration that is billed separately from a restoration procedure (such as a filling).
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.
- Repair or replacement of lost or broken appliances.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- For dental services received prior to the effective date of this policy or received after the coverage under this policy has ended.
- Dental services given by someone other than a licensed Provider (dentist or physician) or their employees.

- Implant services, including maintenance or repair to an implant or implant abutment.
- Dental services for which You would have no legal obligation to pay in the absence of this or like coverage.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.

Pediatric Vision Care

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

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Certificate.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's spouse or Domestic Partner , child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- Visual therapy, such as orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, except as specified in the "What Is Covered" section of this Certificate.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Certificate.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Certificate.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.

CLAIMS PAYMENTS

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

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

Maximum Allowed Amount

General

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

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

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Certificate 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 Certificate.

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 Co-insurance. In addition, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

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

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

Provider Network Status

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

An In-Network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for Your Certificate is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because In-Network

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

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

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

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

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

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

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

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

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

Member Cost Share

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

Your Cost-Share amount and Out-of-Pocket Annual Maximum 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 "Schedule of Benefits" in this Certificate for Your Cost-Share responsibilities and limitations, or call Member Services to learn how this Certificate's benefits or Cost-Share amounts may vary by the type of Provider You use.

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

In some instances You may only be asked to pay the lower 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.

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

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

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

- The Out-of-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; Your Co-insurance responsibility is 20% of $950, or $190 and the remaining allowance from Us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, Your total out-of-pocket responsibility would be $190 (20% Co-insurance 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 Co-insurance 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 Co-insurance responsibility for the Out-of-Network surgeon is 30% of $1500, or $450 after the Out-of-Network Deductible has been met. We allow the remaining 70% of $1500, or $1050. In addition, the Out-of-Network surgeon could bill You the difference between $2500 and $1500, so Your total out-of-pocket charge would be $450 plus an additional $1000, for a total of $1450.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, We may authorize the In-Network Cost-Share amounts (Deductible, Copayment, and/or Co-insurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstances, You must contact Us in advance of obtaining the Covered Service. We also may authorize the In-Network Cost-Share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact Us until after the

Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for authorized services information or to request authorization.

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

Example:

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

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

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

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

Deductible Calculation

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

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

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

The In-Network and Out-of-Network Deductibles are separate and do not apply toward each other.

The family Deductible is also applicable for newborn and adopted children for the first 31 day period following birth or adoption if the child is enrolled or not enrolled following the 31 day period.

Out-of-Pocket Annual Maximum Calculation

The Deductible, Co-insurance, and Copayment amounts incurred in a calendar Year apply to the Out-of-Pocket Annual Maximum.

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

Once the applicable In-Network Out-of-Pocket Annual Maximum is satisfied, no additional In-Network Cost Sharing will be required for the remainder of the calendar Year.

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

In-Network and Out-of-Network Co-insurance and Out-of-Pocket Annual Maximums are separate and do not accumulate toward each other.

The Out-of-Network Out-of Pocket Annual Maximum does not include Co-insurance for any Out-of-Network Human Organ Tissue Transplant.

The Family Membership Out-of-Pocket Annual Maximum is also applicable for newborn and adopted children for the first 31-day period following birth or adoption whether or not the child is enrolled following the first 31-day period.

Benefit Period Maximum

Some Covered Services have a day or visit limit that We will allow during each Benefit Period. This is called the Benefit Period Maximum. When the Deductible applies to a Covered Service that has a limit, the limit will be reduced by the amount applied the Deductible. It does not matter whether or not the Covered Service is paid by Anthem. These limits apply even if You have met the Out-of-Pocket Annual Maximum. These limits apply even if some or all of the claims first applied to meet Your Deductible. See the "Schedule of Benefits" for services that have a Benefit Period Maximum.

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that

results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

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

B. Special Cases: Value-Based Programs

BlueCard Program

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

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

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

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. Exceptions

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

E. BlueCard Worldwide® Program

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

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

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

How Claims are Paid with BlueCard Worldwide

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

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

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

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

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

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

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

Claims Review for Fraud, Waste and Abuse

We have 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.

Claim Forms

If an Out-of-Network Provider does not bill Us directly, the Member must file the claim. You may visit www.anthem.com for claim forms. If We do not furnish a claim form to the Member within 15 days of the Member's request, the Member may submit written proof of the claim and will be considered to have complied with the requirements of this Certificate.

When and Where to Send Claims (Notice of claims)

A completed claim must be sent to Us within 365 days after the date of service. Any claims filed after this time limit may be refused. If You were not able to file a claim within that time We will not refuse or reduce benefits if You can show that is was not reasonably possible and You file as soon as You can.

Claims sent to any authorized agent of the insurer, with information sufficient to identify the Subscriber, is considered notice to the insurer. You should make copies of the bills for Your own records and attach the original bills to the completed claim form. The bills and the claim form must be mailed to:

Anthem
Attn. Claims Department
P.O. Box 5747
Denver, CO 80217-5747

Payment Innovation Programs

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

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

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

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

Relationship of Parties (Us and In-Network Providers)

The relationship between Us and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor are We, or any employee of Ours, an employee or agent of In-Network Providers.

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

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

IF YOU HAVE A COMPLAINT OR AN APPEAL

This section explains what to do if a Member disagrees with Our denial, in whole or in part, of a claim, requested service or supply, and how to file a Complaint, Appeal or Grievance with Us. Please refer to the Definitions section to review defined terms.

Complaints

If the Member has a Complaint about any aspect of Our services or claims processing, the Member should contact Our Member Services department or write Us at:

Anthem
Member Services Department
P.O. Box 17549
Denver, CO 80217-7549

If the Member has questions regarding eligibility or membership, the Member should contact Our Member Services department or write Us at:

Anthem
P.O. Box 172405
Denver, CO 80217-2405

Complaints can be made about many things such as Member services, claims administration, benefit determination, eligibility, quality of care, access to Providers, network adequacy, etc. Some descriptions are very narrow. A trained representative will work to clear up any confusion and resolve the Member's concerns. If the Member is not satisfied with the resolution, the Member can file an Appeal as explained under the APPEALS heading in this section.

Appeals

The Member must request an internal Appeal within 180 calendar days from the date the Member was notified of Our adverse decision. Appeals may be for Preauthorized denials or post-service denials. We will assign an employee to assist the Member in the Appeal process. The Member may send written Appeals to the following address:

Grievance and Appeals
P.O. Box 10330
Reno, NV 89520-0030

The Appeal must state plainly the reason(s) why the Member disagrees with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The Member should include any documents not originally submitted with the claim or request for the service or supply and any other information that the Member feels may have a bearing on the decision.

Through the Appeal process, the Member can access one level of Appeal, and, where appropriate, independent external review. The Member can designate a representative (e.g., the Member's Physician or anyone else of the Member's choosing) to assist the Member with filing the Appeal. In some instances, We may ask the Member to designate the Member's representative in writing. The Member or the Member's representative can review the Member's Appeal file on request, and can present evidence as part of the Appeal process.

Report appeals through healthcare.gov:

https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/

First Level Appeal

First level Appeals will be reviewed by a review board. The members of the board will not have been involved in the original coverage decision. However, a person that was involved in the original coverage decision, or a health care professional with appropriate experience, may answer questions relating to the Appeal. Unless the Member agrees to a longer period, We will provide a decision in writing within 30 calendar days after receipt of the Appeal.

Expedited Appeal

A Member or Member's representative has the right to request an expedited Appeal when the timeframes for a standard review could:

- Seriously jeopardize the Member's life or health;
- Jeopardize the Member's ability to regain maximum function; or
- Create an imminent and substantial limitation on the Member's existing ability to live independently if the Member has a disability.

Expedited Appeals will be resolved as quickly as the Member's medical circumstances require, but not later than 72 hours after receipt of the request. To request an expedited Appeal, the Member, the Member's Provider or the Member's representative can contact Member Services at the phone number on the Member's Identification Card, fax the request to (775) 448-4277 or send a written request to address above.

Independent External Review Appeal

If Our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment the Member requested, the Member may have the right to independent external review, where Our decision will be reviewed by health care professionals who have no association with Us. The Member may also request an independent external review when a claim has been denied based upon a determination that the recommended or requested health care service or treatment is Experimental or Investigational treatment. Except as noted below, in order to request an independent external review, the Member must have first completed a first level Appeal. But if We fail to respond to a Complaint or Appeal within thirty (30) calendar days, and the Member has not agreed to an extension, the Member can request an independent external review and the Member will be considered to have exhausted the internal Appeals process. Also, in some instances, We may (but is not required to) agree to an independent external review even if the Member has not exhausted the First level Appeal.

The request for Independent External Review must be made to the Nevada Office of the Governor, Consumer Health Assistance within four months after the adverse benefit determination or Our final Appeal determination, whichever is later. Except as mentioned below for expedited external review Appeals, the request must be in writing on a form available through the Office of Consumer Health Assistance, which can be contacted at:

555 E. Washington Ave., Ste. 4800
Las Vegas, NV 89101
Phone: 702-486-3587 Fax: 702-486-3586
Toll Free: 1-888-333-1597

- Within 5 business days after receiving the request for external review, the Office of Consumer Health Assistance shall notify the Member, Us and other interested parties that a request for external review has been filed.
- As soon as practical, the Office of Consumer Health Assistance shall assign the Independent Review Organization.
- Within 5 business days after receiving the assignment from the Office of Consumer Health Assistance identifying the Independent Review Organization, We shall provide all documents and materials relating to the adverse determination to the Independent Review Organization.

- Within 5 days after receiving notification from the Office of Consumer Health Assistance and the materials from Us, the Independent Review Organization will review the materials and notify the Member if additional information is needed to conduct the review.
- Additional information must be provided within 5 days after receiving the request.
- The Independent Review Organization shall forward a copy of the additional information to Us within 1 business day after receipt.
- Within 15 days of completing the review, the Independent Review Organization shall submit a copy of its determination to the Member.

When the Member or the Member's representative request Independent External Review, the Member will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision.

Not all requests will be eligible for independent external review. If the Member's claim is determined to be not eligible for independent external review, the Member will be notified of that decision. However, if the Member's denial is eligible for independent external review, an Independent Review Organization will be assigned to conduct the review and issue a decision.

Expedited Independent External Review Appeals

An expedited review may be requested from the Office of Consumer Health Assistance when: (1) an adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the Member received Emergency Services but has not been discharged from the Facility providing the services or care; or (2) failure to proceed in an expedited manner may jeopardize the life or health of the Member or the Member's ability to regain maximum function; or (3) if the claim has been denied based upon a determination that the service or treatment is Experimental or Investigational, the Member's treating Physician certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated. Typically, a Member must complete a first level Appeal prior to requesting external review. However, if the adverse determination involves a denial based on a determination that the service or treatment is Experimental or Investigational and the treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, and, if the Member has a medical condition where the time to complete an expedited Appeal would seriously jeopardize the Member's life, health or ability to regain maximum function, then the Member or Member's representative can request expedited independent external review at the same time as requesting an expedited Appeal. If eligible for expedited independent external review, the Independent Review Organization assigned to the Member's case will then determine whether the independent external review should be decided before the Member's expedited Appeal.

- The Office of Consumer Health Assistance shall approve or deny a request for an expedited external review within 72 hours after it receives proof of whether the request qualifies for expedited external review.
- Upon determination that the request is eligible for an expedited external review, Office of Consumer Health Assistance shall assign an Independent Review Organization within 1 working day after approving the request.
- We shall provide all documents and information used to make the adverse determination to the Independent Review Organization within 24 hours after receiving notice from the Office of Consumer Health Assistance assigning the request.
- The Independent Review Organization must complete its review within 48 hours (unless the Member and We agree to a longer period) after receiving the assignment.
- Within 24 hours after completing the assignment, the Independent Review Organization must notify the Member, Physician and Us of its determination by telephone, followed up in writing within 48 hours.

The Member or the Member's Provider can request (orally or in writing) an expedited independent external review. Requests for expedited independent external review must be made to the Office of Consumer Health Assistance within four months of an adverse benefit determination or Our final Appeal determination, whichever is later. The Office of Consumer Health Assistance can be reached at:

555 E. Washington Ave., Ste. 4800
Las Vegas, NV 89101
Phone: 702-486-3587 Fax: 702-486-3586
Toll Free: 1-888-333-1597

When the Member or the Member's representative request independent external review, the Member will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision.

Not all requests will be eligible for independent external review. If the Member's claim is determined to be not eligible for independent external review, the Member will be notified of that decision. However, if the Member's denial is eligible for independent external review, an Independent Review Organization will be assigned to conduct the review and issue a decision.

Appeals Involving Independent Medical Evaluations

If We require an independent medical, dental or chiropractic evaluation to make a final determination of benefits or care, We may require the Member to submit to the independent evaluation. The evaluation will be conducted by a Physician, dentist or chiropractor who is certified to practice in the same field of practice as the primary treating Physician, dentist or chiropractor, or who is formally educated in that field.

The independent evaluation must include a physical examination of the patient, unless deceased, and a personal review of all X-rays and reports prepared by the primary treating Physician, dentist or chiropractor. A certified copy of all reports of findings must be sent to the primary treating Physician, dentist or chiropractor and the Member within 10 working days after the evaluation. If the Member disagrees with the findings of the evaluation, the Member must submit an Appeal to Us, pursuant to the procedure for binding arbitration as established by the American Arbitration Association, within 30 days after receipt of the findings of the evaluation. Upon receipt of an Appeal, We will notify the primary treating Physician, dentist or chiropractor in writing.

We will not limit or deny coverage for care related to a disputed claim that requires an independent medical evaluation while the dispute is in arbitration. However, if We prevail in the arbitration, the primary treating Physician, dentist or chiropractor may not recover any payment from Us, the Subscriber or the patient for services that the Physician, dentist or chiropractor provided to the patient after receiving written notice from Us.

Grievances

The Member may send a written Grievance to the following address within 60 days of the event:

Anthem
Quality Management Department
P.O. Box 4310
Woodland Hills, CA 91365

Our Quality Management Department will acknowledge receipt of, and investigate, the Member's Grievance. We treat each Grievance investigation in a strictly confidential manner.

Legal Action

Before a Member takes legal action on a claim decision, the Member must first follow the process outlined under the heading "Appeals" in this section and the Member must meet all the requirements of this Certificate.

No action in law or in equity shall be brought to recover on this Certificate prior to expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this Certificate. No such action shall be brought at all unless brought within three years after claim has been filed as required by the Certificate.

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

Dental Coverage Appeals

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

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

Blue View Vision Coverage Appeals

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

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

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

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

Subscriber Eligibility

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

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

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

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

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

   - Not be living in an institution;
   - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security;
   - Not be emancipated;
   - Not be receiving optional State supplementary payments (SSP); and
   - Reside in the Service Area of the Exchange.
6. Agree to pay for the cost of Premium that We require;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B and/or D;
10. Not be covered by any other group or individual health benefit plan.

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

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

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

For tax households with Members in multiple Exchange Service Areas:

1. If all of the Members of a tax household are not living within the same Exchange Service Area, any Member of the tax household may enroll in a QHP through any of the Exchanges for which one of the Tax Filers meets the residency requirements.
2. If both Spouses in a tax household enroll in a QHP through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependent Eligibility

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

1. The Subscriber's legal Spouse.
2. The Subscriber's Domestic Partner - Domestic Partner is a person, other than a Spouse, with whom one cohabits. A Domestic Partner is only eligible for coverage if:
   - He or she has chosen to share one another's lives in an intimate and committed relationship of mutual caring.
   - Desired by their own free will to enter into a Domestic Partnership.
   - The NV Secretary of State has issued a Certificate of Registered Domestic Partnership.
   - He or she shares a common residence on at least a part time basis.
   - He or she is mentally competent.
   - He or she is at least 18 years old; is not related to the Member in any way (including by blood or adoption) that would prohibit him or her from being married under State law.
   - He or she is not married to or separated from anyone else.
     a. For purposes of this Certificate, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
     b. A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
     c. To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3. The Subscriber's or the Subscriber's Spouse's children, including stepchildren, newborn and legally adopted children who are under age 26.
4. Children for whom the Subscriber or the Subscriber's Spouse is a legal guardian and who are under age 26.

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

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

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

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

Open Enrollment

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

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

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

Changes Affecting Eligibility and Special Enrollment

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

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

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

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

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

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's Spouse will be covered for an initial period of 31 days from the date of birth. This would also apply to the newly born child of a covered Dependent child. To continue coverage beyond the first 31 days, please contact the Exchange within 60 days of the date of birth to add the child to the Subscriber's Certificate and You must pay Anthem timely for any additional Premium due.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to You. The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption. Please contact the Exchange within 60 days of the placement for adoption or date of adoption

to add the child to the Subscriber's Certificate and You must pay Anthem timely for any additional Premium due.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's Spouse files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Certificate must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Court Ordered Health Coverage

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

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

Effective Date of Coverage

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

Effective Dates for Special Enrollment periods:

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

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

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

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

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

Notice of Changes

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

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

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

Report life changes and qualifying life events to healthcare.gov:
https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/

Statements and Forms

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

WHEN MEMBERSHIP ENDS (TERMINATION)

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

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

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

"Grace Period" refers to either:

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

Effective Dates of Termination

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

1. In the case of termination initiated by the Member, the last day of coverage is:
   a) The termination date specified by the Member, if reasonable notice is provided;
   b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
   c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination Effective Date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of Domestic Partnership, overage Dependent, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination Effective Date.
4. In the case of a termination for non-payment of Premium and the 3-month Grace Period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month Grace Period.
5. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium is paid, consistent with existing State laws regarding Grace Periods.
6. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.

7. The day following the Member's death. When a Subscriber dies, the surviving Spouse or Domestic Partner of the deceased Subscriber, if covered under the Certificate, shall become the Subscriber.

"Reasonable notice" is defined as fourteen days prior to the requested Effective Date of termination.

Guaranteed Renewable

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

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

Loss of Eligibility

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

Rescission

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

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

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

Discontinuation of Coverage

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

Grace Period

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

If the Subscriber does not pay the required Premium by the end of the Grace Period, the Certificate is terminated. The application of the Grace Period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a Grace Period of at least three consecutive months. During the Grace Period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the Grace Period, the last day of coverage will be the last day of the first month of the 3-month Grace Period. We must pay claims during the first month of the Grace Period but may pend claims in the second and third months subject to Our right to terminate the Certificate as provided herein. You will be liable to Us for the Premium payment due including those for the Grace Period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month Grace Period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Certificate has a Grace Period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the Grace Period. During the Grace Period, the Certificate will stay in force and claims will be pended unless prior to the date Premium is due You give timely written notice to Us that the Certificate is to be terminated. If You do not make the full Premium payment during the Grace Period, the Certificate will be terminated on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the last day through which Premium is paid.

After Termination

Once this Certificate is terminated, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may terminate the enrollment of any Member from the plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

Insurance Premiums

How Premiums are Established and Changed

Premiums are the monthly charges the Member must pay Us to establish and maintain coverage. The Premium for this Certificate may change subject to, and as permitted by, applicable law.

Prior to a Premium change, We will send out written notification 60 days in advance of such change. We are not required to notify the Member of a Premium increase when a Member enters into a new age bracket. If the Member's Premium is paid beyond the Effective Date of the change, We may require the Member to pay an additional Premium or accept a refund, whichever is necessary. If the age of the Member is misstated, all amounts payable for the correct age shall be adjusted and billed to the Member.

It is the Subscriber's responsibility to pay Premiums to Us. Under no circumstances will Premium payments made on any Member's behalf or any Member be accepted from a Physician, a Hospital or any other Provider of the Subscriber's health care services or any federal or State agency. The receipt of a Premium payment from such a Provider or agency may result in termination of the Subscriber's coverage.

Administrative Fee

An administrative fee of $20 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Us for any reason.

Note: We may offer incentives to Members who enroll to automatically pay Premiums electronically instead of receiving a paper bill every month.

The Subscriber must notify Us of an address change by submitting an Enrollment Application/Change Form, visiting Our website at www.anthem.com, or calling Our Member Services department. Failure to receive a Premium notice due to an unreported address change (or any other reason) does not relieve the Member from the responsibility to pay required Premiums by the Premium due date.

Premium Not Received on Time

If Premiums are not paid within the Grace Period, coverage under this Certificate will automatically terminate. Where the law allows, and subject to the Grace Period section of this Certificate, termination may be effective retroactively to the last date of the period for which Premium has been paid. We will not pay for any services provided to Members on or after the date of termination. All claims paid after termination will be retroactively adjusted.

We will mail written notice of any intention not to renew this Certificate beyond the period for which the Premium has been accepted not less than 30 days prior to the Premium due date. We will mail the notice to the Subscriber's latest address in Our Membership records. A Grace Period will be granted for the payment of each Premium falling due after the first Premium, during which Grace Period the Certificate shall continue in force.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to You. For example, sometimes We may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, We may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, We may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network

Providers may be required to make payment to Us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to Us under these programs.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike or other cause beyond Our control, We may be unable to process Member claims on a timely basis. No legal action or lawsuit may be taken against Us due to a delay caused by any of these events.

Changes to the Certificate

No agent or employed by Us may change this Certificate by giving incomplete or incorrect information, or by contradicting the terms of this Certificate. Any such situation will not prevent Us from administering this Certificate in strict accordance with its terms. Oral or written statements do not supersede the terms of this Certificate.

Continuity of Care

If Your In-Network Provider leaves Our network because We have terminated their contract without cause, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still receive In-Network benefits. "Active treatment" includes:

1. An ongoing course of treatment for a life-threatening condition.
2. An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits).
3. The second or third trimester of pregnancy and through the postpartum period.
4. An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen Your condition or interfere with anticipated outcomes. An "ongoing course of treatment" includes treatments for mental health and substance use disorders.

In these cases, You may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If You wish to continue seeing the same Provider, You or Your Doctor should contact Member Services for details. Any decision by Us regarding a request for Continuity of Care is subject to the Appeals Process.

Fraudulent Insurance Acts

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance within the Department of Business and Industry.

Insurance fraud results in cost increases for health care coverage. Members can help decrease these costs by doing the following:

- Be wary of offers to waive Copayments or Deductible. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the Explanation of Benefits received from Us. If there are any discrepancies, call Our Member Services department.
- Be very cautious about giving the Member's health insurance coverage information over the phone.

If fraud is suspected, Members should contact Our Member Services department.

We reserve the right to recoup any benefit payments paid on behalf of a Member if the Member has committed fraud or material misrepresentation in applying for coverage in or receiving or filing for benefits.

Medical Policy and Technology Assessment

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

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Member's Obligation to Supply Information and Cooperate

The Member must provide Us with any information We consider necessary to determine whether, or to what extent, services are covered under this Certificate, or to carry out the other provisions of this Certificate.

The Member agrees to cooperate at all times (including while they are hospitalized) by allowing Us access to their medical records to investigate claims and verify information provided in the Nevada Individual Enrollment Application.

No Withholding of Coverage for Necessary Care

We do not compensate, reward or incent, financially or otherwise, Our associates for inappropriate restrictions of care. We do not promote or otherwise provide an incentive to employees or Physician reviewers for withholding benefit approval for Medically Necessary services to which the Member is entitled. Utilization Review and benefit coverage decision making is based on appropriateness of care and service and the applicable terms of this Certificate.

We do not design, calculate, award or permit financial or other incentives based on the frequency of: (1) denials of Authorization for coverage; (2) reductions or limitations on Hospital lengths of stay, medical services or charges; or (3) telephone calls or other contacts with health care Providers or Members.

Notice of Privacy Practices

We are committed to protecting the confidential nature of Members' medical information to the fullest extent of the law. In addition to various laws governing Member privacy, We have Our own privacy policies and procedures in place designed to protect Member information. We are required by law to provide individuals with notice of Our legal duties and privacy practices. To obtain a copy of this notice, visit Our website or contact Our Member Services department.

Paragraph Headings

The headings used throughout this Certificate are for reference only and are not to be used by themselves for interpreting the provisions of the Certificate.

Physical Examinations and Autopsies

We have the right and opportunity, at Our expense, to request an examination of the person covered by Us when and as often as it may reasonably be required during the review of a case or claim. On the death of a Member, We may request an autopsy where it is not forbidden by law.

Program Incentives

We may offer incentives from time to time, at Our discretion, in order to introduce You to covered programs and services available under this plan. The purpose of these incentives include, but is not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, encouraging You to update Member-related information and encouraging You to enroll automatically to pay Premiums electronically. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member Cost-shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.

Refusal to Follow Recommended Treatment

If a Member refuses treatment that has been recommended by Our In-Network Provider, the Provider may decide that the Member's refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a Member's wishes, when they are consistent with the Provider's judgment. If a Member refuses to follow the recommended treatment or procedure, the Member is entitled to see another Provider of the same specialty for a Second Opinion. The Member can also pursue the Appeal process.

Reserve Funds

No Member is entitled to share in any reserve or other funds that may be accumulated or established by Us, unless We grant a right to share in such funds.

Right of Recovery and Adjustment

Whenever payment has been made in error, We will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the calendar Year in which the error is discovered.

We have oversight responsibility of compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, We have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We may not give You notice of overpayments made by us or You if the recovery method makes providing such notice administratively burdensome.

Sending Notices

All Subscriber notices are considered sent to and received by the Subscriber when deposited in the United States mail with postage prepaid and addressed to either:

The Subscriber at the latest address in Our membership records.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that You have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under Your plan. These programs are not guaranteed and could be discontinued at any time.

We will give You the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards or retailer coupons, which we encourage You to use for health and wellness related activities or items. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If You have questions about whether receipt of a gift card or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.)

Workers' Compensation

To recover benefits under workers' compensation insurance for a work-related illness or injury, the Member must pursue the Member's rights under the Workers' Compensation Act or any of the employer liability laws that may apply. This includes filing an Appeal with the Nevada Division of Industrial Relations. We may pay conditional claims during the Appeal process if the Member signs a reimbursement agreement to reimburse Us for 100 percent of benefits paid that duplicate benefits paid from another source.

Services and supplies resulting from work-related illness or injury are not a benefit under this Certificate, except for corporate officers who have opted out of Workers' Compensation coverage, pursuant to State or federal law, prior to the illness or injury. This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness covered under:

- Occupational disease laws.
- Employer's liability insurance.
- Municipal, state, or federal law.
- Workers' Compensation Act.

We will not pay benefits for services and supplies resulting from a work-related illness or injury **even if other benefits are not paid because:**

- The Member fails to file a claim within the filing period allowed by the applicable law.
- The Member obtains care that is not authorized by workers' compensation insurance.
- The Member's employer fails to carry the required workers' compensation insurance. In this case, the employer becomes liable for any of the employee's work related illness or injury expenses.
- The Member fails to comply with any other provisions of the Workers' Compensation Act.

Duplicate Coverage

If a Member is covered under this Certificate and is also covered by another Anthem individual Certificate, the Member is limited to the one Certificate elected by the Member, the Member's beneficiary or the Member's estate, as the case may be, and We will return all Premiums paid for all other such policies. However, We will deduct any benefits paid under the individual Certificate from the Premiums being refunded.

Medicare-Eligible Members

The Subscriber and Dependents who are non-Medicare eligible and who reside in Nevada are eligible to enroll for coverage. A Member who is under age 65 at the time of enrollment but who later becomes eligible for Medicare Part A, B, C and/or Part D, is eligible to continue coverage with this coverage as secondary to any Medicare benefits. Medicare will be the primary carrier for such Members.

Network Access Plan

We strive to provide Provider networks in Nevada that addresses Your health care needs. The Network Access Plan describes Our Provider network standards for network sufficiency in service, access and availability, as well as assessment procedures We follow in Our effort to maintain adequate and accessible networks. To request a copy of this document, call Member Services. This document is also available on Our website or for in-person review at 9133 W. Russell Road, Las Vegas, NV.

Not Liable for Provider Acts or Omissions

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

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make this Certificate more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of this Certificate, We have the authority, in Our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Certificate. We reserve the right to discontinue a pilot or test program at any time.

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs and products to Our members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics). In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the plan but are in addition to plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Certificate and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

MEMBER RIGHTS AND RESPONSIBILITIES

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

You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your Policy.
- Work with Your doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect Us to keep Your personal health information private by following Our privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health plan, and share Your feedback. This includes information on:
    - Our company and services;
    - Our network of health care Providers;
    - Your rights and responsibilities;
    - the rules of Your health plan;
    - the way Your health plan works.
- Make a Complaint or file an Appeal about:
    - Your health plan and any care You receive;
    - any Covered Service or benefit decision that Your health plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care You may get in the future. This includes asking Your doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health plan rules and policies.
- Choose an In-network Primary Care Physician, also called a PCP, if Your health plan requires it.
- Treat all doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give Us, Your doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health plan. This may include information about other health insurance benefits You have along with Your coverage with us.
- Inform Member Services if You have any changes to Your name, address or family Members covered under Your Policy.

If You would like more information, have comments, or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your ID card.

We want to provide high quality benefits and Member Services to Our Members. Benefits and coverage for services given under the Policy are overseen by Your Certificate of Coverage or Schedule of Benefits and not by this Member Rights and Responsibilities statement.

DEFINITIONS

The following terms, defined in this section, are capitalized throughout the Certificate so they are easy to identify.

Accidental Injuries

Unintentional internal or external injuries, e.g., strains, animal bites, burns, contusions and abrasions which result in trauma to the body. Accidental Injuries are different from illness-related conditions.

Acupuncture Services

The treatment of a disease or condition by inserting special needles along specific nerve pathways for therapeutic purposes. The placement of the needles varies with the disease or condition being treated.

Acute Care

Care that is provided in an office, Urgent Care setting, Emergency room or Hospital for a medical illness, accident or injury. Acute Care may be Emergency, urgent or non-urgent, but is not primarily preventive in nature.

Acute Rehabilitation Therapy

Inpatient Rehabilitation Therapy that is required for a short period of time. Acute Rehabilitation Therapy services are unrelated to acute Hospital medical or surgical care.

Advance Payments of the Premium Tax Credit (APTC)

The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Alcoholism Treatment Center

A Hospital, other medical facility or facility which is licensed by the health division of the department of human resources, accredited by the Joint Commission of Accreditation of Healthcare Organizations and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities. Outpatient facility and Provider office services must be performed by a Physician, licensed clinical psychologist or other Professional Provider who is properly licensed or certified to practice psychotherapy.

Alternative/Complementary Medicine

For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

Ambulance

A specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an Ambulance.

American Indian

American Indian is an individual who is a Member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Ancillary Services

Services and supplies (in addition to room services) that Hospital, Alcoholism Treatment Centers and other facilities bill for and regularly make available for the treatment of the Member's condition. Such services include, but are not limited to:

- Use of operating room, Recovery room, Emergency room, treatment rooms and related equipment.
- Drugs and medicines, biologics (medicines made from living organisms and their products), and pharmaceuticals.
- Dressings and supplies, sterile trays, casts, and splints.
- Diagnostic and therapeutic services.
- Blood processing and transportation and blood handling costs and administration.

Anesthesia

The loss of normal sensation or feeling. There are two different types of Anesthesia:

- General Anesthesia, also known as total body Anesthesia, causes the patient to become unconscious or "put to sleep" for a period of time.
- Local Anesthesia causes loss of feeling or numbness in a specific area usually injected with a local anesthetic drug such as Lidocaine.

Anthem

Rocky Mountain Hospital and Medical Service, Inc., doing business as Anthem Blue Cross and Blue Shield. Also referred to as "Anthem".

Appeal

A process for reconsideration of Our decision regarding a Member's claim.

Authorization

Approval of benefits for a covered procedure or service.

Balance Billing

When a Provider bills You for the difference between the Provider's charge and the allowed amount. For example, if the Provider's charge is $100 and the allowed amount is $70, the Provider may bill You for the remaining $30. An In-Network Provider may not Balance Bill You for Covered Services.

Benefit Period

The Benefit Period for this plan begins on Your Effective Date and continues until December 31 of that year. Later Benefit Periods are for a one Year period which start and end on succeeding calendar Years.

Benefit Period Maximum

The maximum number of days, visits, or dollar amount that We will pay for specific Covered Services during a Benefit Period.

Billed Charges

A Provider's regular charges for services and supplies as offered to the public generally and without any adjustment for any applicable In-Network Provider or other discounts.

Biosimilar/Biosimilars

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

Birth Abnormality

A condition that is recognizable at birth, such as a fractured arm.

Brand Name Drug

The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Care Management

A plan of Medically Necessary and appropriate health care which is aimed at promoting more effective interventions to meet Member needs and optimize care. Care Management is also referred to as case management.

Certificate

This document, which explains the benefits, limitations, exclusions, terms and conditions of the health coverage.

Chemotherapy

Drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractic Services

A system of therapy in which disease is considered the result of abnormal function of the nervous system. This method of treatment usually involves manipulation of the spinal column and other body structures.

Chronic Rehabilitation Therapy

Inpatient Rehabilitation Therapy that is required for more than six months and may continue for the remainder of the person's life. Chronic Rehabilitation Therapy is also known as non-acute and long-term acute.

Clinical Trial

The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Clinically Equivalent

Drugs We determine that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Co-insurance plus any Deductibles You owe. For example, if the health insurance or Certificate's allowed amount for an office visit is $100 and You've met Your Deductible, Your Co-insurance payment of 20% would be $20. Your Co-insurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Complaint

An expression of dissatisfaction with Our services or the practices of an In-Network Provider, whether medical or non-medical in nature.

Congenital Defect

A defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.

Consultation/Second Opinion

A service provided by another Physician who gives an opinion about the treatment of the Member's condition. The consulting Physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

Copayment

A fixed amount (for example, $15) You pay for a covered health care service, usually when You receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to the Deductible.

Cosmetic Services

Cosmetic Services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric or psychological reasons.

Cost-Share

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

Covered Services

Services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Certificate is in force.
- Not Experimental/Investigational or otherwise excluded or limited by the Certificate, or by any amendment or rider thereto.
- Authorized in advance by Us if such Preauthorization is required by the Certificate.

Covered Services are subject to the Maximum Allowed Amount which is the maximum amount payable for Covered Services You receive, up to but not to exceed charges actually billed. If a service is not covered or if You have exceeded Your benefits for Covered Services, the Provider is not limited by the Maximum Allowed Amount and they can charge up to the billed amount.

Covered Transplant Procedures

Any Medically Necessary human organ and stem cell/ bone marrow transplants and transfusions as listed as a Covered Services in this Certificate or as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative.

Custodial Care

Care provided primarily to meet the personal needs of the Member. This includes help in walking, bathing or dressing. It also includes, but is not limited to, preparing food or special diets, feeding, administration of medicine that is usually self-administered or any other care which does not require continuing services of specialized medical personnel.

Deductible

The dollar amount of Covered Services, listed in the “Schedule of Benefits”, You pay in a Benefit Period before this Certificate will pay for any remaining Covered Services during that Benefit Period.

Dental Services

Services, supplies, appliances and related expenses for treatment of conditions related to the teeth or structures supporting the teeth, or for improving dental clinical outcomes.

Dentally Necessary Orthodontic Care

A service for Pediatric Members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be

covered. See the Dentally Necessary Orthodontic Care benefit description in the Dental Services – Dental Care for Pediatric Members section.

Dependent

A Member of the Subscriber's family who meets the requirements listed in the MEMBERSHIP section and who has enrolled in the Certificate.

Designated Pharmacy Provider

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

Discharge Planning

The evaluation of a Member's medical needs and arrangement of appropriate care after discharge from a facility.

Distant Site

The location of the site where a Telehealth Provider of health care is providing Telehealth services to a patient located at an Originating Site.

Domestic Partner

Domestic Partner is a person, other than a Spouse, with whom one cohabits. A Domestic Partner is only eligible for coverage if:

- He or she has chosen to share one another's lives in an intimate and committed relationship of mutual caring.
- Desired by their own free will to enter into a Domestic Partnership.
- The NV Secretary of State has issued a Certificate of Registered Domestic Partnership.
- He or she shares a common residence on at least a part time basis.
- He or she is mentally competent.
- He or she is at least 18 years old; is not related to the Member in any way (including by blood or adoption) that would prohibit him or her from being married under State law.
- He or she is not married to or separated from anyone else.

Durable Medical Equipment

Any equipment that can withstand repeated use, is made to serve a medical condition, is useless to a person who is not ill or injured, and is appropriate for use in the home.

Effective Date

The date coverage under this Certificate begins.

Elective Surgery

A procedure that does not have to be performed on an Emergency basis and can be reasonably delayed. Such Surgery may still be considered Medically Necessary.

Emergency

The sudden onset of a medical condition or accident manifesting itself in acute symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the Member.
- Serious jeopardy to the health of an unborn child.
- Serious impairment to bodily functions.
- Serious and permanent dysfunction of any bodily organ or part

Emergency Medical Condition (Emergency)

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

- Placing the health of the individual or another person (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 or behavioral health screening examination (as required under federal law) 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 as are required under federal law 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 affect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Experimental/Investigational

(a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which We determine in its sole discretion to be Experimental or Investigational.

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

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

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other State or federal regulatory agency, and such final approval has not been granted.
- Has been determined by the FDA to be contraindicated for the specific use.
- Is provided as part of a clinical research protocol or Clinical Trial (except where coverage for such trial is mandated by applicable law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

(b) Any service not deemed Experimental or Investigational based on the criteria in subsection (a) We may still be deemed to be Experimental or Investigational. In determining whether a service

is Experimental or Investigational, We will consider the information described in subsection (c) and assess all of the following:

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

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

- Randomized, controlled, Clinical Trials published in authoritative, peer-reviewed United States medical or scientific journal.
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies.
- Documents issued by and/or filed with the FDA or other federal, State or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- Documents of an IRB or other similar body performing substantially the same function.
- Consent documentation(s) used by the treating Physicians, other medical professionals or facilities, or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- Medical records.
- The opinions of consulting Providers and other experts in the field.

(d) We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational.

Explanation of Benefits

Also known as an EOB, a printed form sent by an insurance company to a Member after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of Provider, amount covered and patient balance. An explanation of Medicare benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Certificate. The Facility must be licensed, accredited, registered and approved by the Joint Commission or The Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by Us.

Family Membership

Membership that covers 2 or more persons (the Subscriber and 1 or more Dependents).

Formulary

The term Formulary means a listing of Prescription Drugs that are determined by Us in its sole discretion to be designated as covered drugs. The List of approved Prescription Drugs developed by Us in Consultation with Physicians and pharmacists has been reviewed for their quality and cost effectiveness.

This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for Our other products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Us. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs

The term Generic Drugs means a Prescription Drug 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.

Grievance

A written Complaint about the quality of care or service received from a Provider.

Habilitative Services

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

Hemodialysis

The treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Holistic Medicine

Various preventive and healing techniques, that are theoretically based on the influence of the external environment and the various ways different body tissues affect each other along with the body's natural healing powers.

Home Delivery (Mail Order) Pharmacy:

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Pharmacy Drugs) through a Home Delivery (Mail Order) service upon an authorized health care professional's order.

Home Health Agency

An agency certified by the Nevada Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act," as amended, for home health agencies. A Home Health Agency is primarily engaged in arranging and providing nursing services, home health aide services, and other therapeutic and related services.

Home Health Care

The general term for skilled nursing, Physical Therapy, Speech Therapy, Occupational Therapy, infusion therapy and other health-related services provided at home by an accredited agency.

Home Health Services

The following services provided by a certified Home Health Agency under a plan of care to eligible Members in their place of residence: professional nursing services; certified nurse aide services; Medical Supplies, equipment, and appliances suitable for use in the home; and Physical Therapy, Occupational Therapy, Speech Pathology and audiology services.

Hospice Agency

An agency licensed by the Nevada Department of Public Health and Environment to provide Hospice Care in this State. A hospice is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual and sociological care for

terminally ill individuals and their families within a continuum of inpatient care, Home Health Care and follow-up bereavement services available 24 hours a day, seven days a week.

Hospice Care

A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the State or locality in which it operates.

Hospital

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

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission.

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

Identification Card

The card We give You that shows Your Member identification, group number, and the plan You have.

Individual Membership

Membership covering one person (the Subscriber).

In-Network Provider

A Provider that has a contract, either directly or indirectly, with Us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Pharmacy

An In-Network Pharmacy is a Pharmacy that has an In-Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. In-Network Pharmacies may be based on a restricted network, and may be different than the network of In-Network Pharmacies for Our other products. To find an In-Network Pharmacy near You, call Member Services at (800) 700-2533

Intensive Outpatient Program

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

Interchangeable Biologic Product

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

IUD

An acronym for intrauterine device, a device inserted into the uterus to prevent pregnancy.

Laboratory and Pathology Services

Testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material that has been removed from the body.

Long-Term Acute Care Facility

Also known as an LTAC facility, an institution that provides an array of long-term critical care services to Members with serious illnesses or injuries. Long-Term Acute Care is provided for patients with complex medical needs. These include high-risk pulmonary patients with ventilator or tracheotomy needs, medically unstable patients, extensive wound care or post operative Surgery wound Members, and low level closed head injury Members. LTAC facilities do not provide care for low intensity patient needs.

Maintenance Medication

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

Maintenance Pharmacy

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

Managed Care

A system of health care delivery the goal of which is to give Members access to quality, cost effective health care while optimizing utilization and cost of services, and measuring Provider and coverage performance.

Maternity Services

Services required by a Member for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services.

Maximum Allowed Amount

The maximum amount that We will allow for Covered Services You receive. For more information, see the “Claims Payments” section.

Medically Necessary

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that We, subject to a Member’s right to Appeal, as described in the “If You Have A Complaint Or An Appeal” section, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a Physician and/or licensed, certified or registered Provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention (“cost effective” does not mean lowest cost). It does mean that as to the diagnosis or treatment of the Member’s illness, injury or disease, the service is: (1) not more costly than an alternative service or

sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.
- Not Experimental/Investigational.
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Certificate.

The fact that a Physician and/or Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

Medical Supplies

Items (except Prescription Drugs) required for the treatment of an illness or injury.

Medicare

A federally funded health insurance program that provides benefits for people age 65 and older. Some individuals under age 65 who are disabled or who have end stage kidney disease also are eligible for Medicare benefits.

Member

The Subscriber or any Dependent who is enrolled for coverage under this Certificate.

Mental Health Condition

Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or Substance Abuse condition. It does not include autism or pervasive developmental disorders, which under State law are considered medical conditions. It includes the following conditions, which under State law are considered Severe Mental Illness: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Myotherapy

The physical diagnosis, treatment and pain management of conditions which cause pain in muscles and bones.

Occupational Therapy

The use of educational and rehabilitative techniques to improve a Member's functional ability to live independently. Occupational Therapy requires that a properly accredited occupational therapist (OT) or certified Occupational Therapy assistant (COTA) perform such therapy.

Organ Transplants

A surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body substances, such as stem cells or bone marrow, for the purpose of treatment and reimplanting the removed organ or tissue into the same person.

Originating Site

The location of the site where a patient is receiving Telehealth services from a Provider of health care located at a Distant Site.

Orthopedic Appliance

A rigid or semi-rigid support used to eliminate, restrict or support motion in a part of the body that is diseased, injured, weak or malformed.

Orthotic

A support or brace for weak or ineffective joints or muscles.

Out-of-Network Provider

A Provider that does not have an agreement or contract with Us, or Our Subcontractor(s) to give services to Our Members. You will often get a lower level of benefits when You use Out-of-Network Providers.

Out-of-Pocket Annual Maximum

A specified dollar amount of expense incurred for Covered Services in a calendar Year as listed in the "Schedule of Benefits". Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the "Schedule of Benefits" for other services that may not be included in the Out-of-Pocket Annual Maximum. When the Out-of-Pocket Annual Maximum is reached, no additional Cost-Sharing is required unless otherwise specified in this Certificate.

Partial Hospitalization Program

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

Pharmacy

The term Pharmacy means a place licensed by State law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a prescription from Your Doctor.

Pharmacy and Therapeutics (P&T) Process

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

Physical Therapy

The use of physical agents to treat disability resulting from disease or injury. Physical agents used include heat, cold, electrical currents, Ultrasound, ultraviolet radiation, massage and therapeutic exercise. Physical Therapy must be performed by a Physician or registered physical therapist.

Preauthorization

A process in which requests for services are reviewed prior to service for approval of benefits, length of stay and appropriate location.

Precertification

Please see the section "Requesting Approval for Benefits" for details.

Predetermination

Please see the section "Requesting Approval for Benefits" for details.

Premium

Monthly charges that the Member and/or group must pay to establish and maintain coverage.

Prescription Drug Deductible

The term Deductible means the amount of charges You must pay for any Covered Services and Prescription Drugs in a Benefit Period before any benefits are available to You under this Certificate. Your Deductible is stated in Your "Schedule of Benefits". The Deductible may be separate from the annual Deductibles for medical benefits and may or may not accumulate towards satisfying the medical In-Network Provider Deductibles.

Prescription Drug Maximum Allowed Amount

The maximum amount We allow for any Prescription Drug. The amount is determined by Us using Prescription Drug costs information provided to Us by the Pharmacy Benefits Manager (PBM).

Prescription Drug (Drug)

The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes insulin, Diabetic supplies, and syringes.

Prescription Legend Drug

A medicinal substance dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution Federal law prohibits dispensing without a prescription". Compound medications that contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Certificate.

Preventive Care

Comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for You. The Physician may work in family practice, general practice, internal medicine, pediatrics or any other practice allowed by the plan.

Private Duty Nursing Services

Services that require the training, judgment and **technical** skills of an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Such services must be prescribed by the attending Physician for the **continuous** medical treatment of the condition.

Prosthesis

A device that replaces all or part of a missing body part.

Prostate Screening

Testing to identify an increased risk of prostate cancer in the absence of any abnormal symptoms.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that State law says We must cover when they give You services that State law says We must cover. Providers that deliver Covered Services are described throughout this Certificate. If You have a question about a Provider not described in this Certificate please call the number on the back of Your Identification Card.

Qualified Health Plan or QHP

Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer

Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Radiation Therapy

X-ray, radon, cobalt, betatron, telocobalt, radioactive isotope treatment and similar treatments for malignant diseases and other medical conditions.

Reconstructive Surgery

In this Certificate Reconstructive Surgery includes those procedures that are intended to address a significant variation from normal related to Accidental Injury, disease, trauma, treatment of a disease or Congenital Defect.

Rehabilitative Services

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

Residential Treatment Center/Facility:

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

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

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major Pharmacies or retail stores. Medical services are typically provided by Physician assistants and nurse practitioners.

Retail Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Pharmacy Drugs) through a licensed pharmacist or Home Delivery (Mail Order) service upon an authorized health care professional's order.

Schedule of Benefits

The document, found in the front of the Certificate, which identifies the type of coverage and Cost-Shares including Deductible, Copayment and Co-insurance information.

Second Opinion

A visit to another Professional Provider (following a first visit with a different Provider) for review of the first Provider's opinion of proposed Surgery or treatment.

Self-Administered Drugs

The term Self-Administered Drugs means drugs that are administered which do not require a medical professional to administer.

Service Area

The geographic area where You can get Covered Services from an In-Network Provider, as approved by State regulatory agencies.

Single Coverage

Membership covering one person (the Subscriber).

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for You after a Hospital stay when You have a condition that needs more care than You can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by Us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Special Care Units

Special areas of a Hospital with highly skilled personnel and special equipment to provide Acute Care with constant treatment and observation.

Specialist

A professional, usually a Physician, devoted to a specific disease, condition or body part. Examples include, but not limited to psychiatrist, orthopedist, obstetrician, gynecologist and cardiologist.

Specialty Drug List

A list of Specialty Pharmacy Drugs as determined by Us which must be obtained from Our In-Network Specialty Pharmacy affiliate and which are billed under the Pharmacy benefit.

Specialty Drugs

The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at Retail Pharmacies.

Specialty Pharmacy

A Pharmacy that is designated by Us, other than a Retail Pharmacy, Home Delivery (Mail-Order), or other Specialty Pharmacy that provides high cost, biotech drugs which are usually injected, oral, infused or inhaled and used for the treatment of acute or chronic diseases.

Specialty Pharmacy Drugs

These are high-cost, injectable, infused, oral or inhaled medications as listed on Our Specialty Drug List that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy.

Speech Therapy (also called Speech Pathology)

Services used for diagnosis and treatment of speech and language disorders. A licensed and accredited speech/language pathologist must perform Speech Therapy.

Spouse

A Subscriber's legal Spouse, including a Domestic Partner.

State

State means each of the 50 States and the District of Columbia.

Step Therapy

Protocol that means that Members may need to use one type of medication before another medication will be covered.

Subscriber

The Member in whose name the membership with Us is established.

Substance Abuse

Means alcoholism, drug and other Substance Abuse. Alcoholism and Substance Abuse are conditions brought about when an individual uses alcohol, drugs or other substances in such a manner that his or her health is impaired and/or ability to control actions is lost.

Surgery

Any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, including, but not limited to cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include usual and related Anesthesia and pre- and post-operative care, including recasting.

Tax Dependent

The term Tax Dependent has the same meaning as the term Dependent under the Internal Revenue Code.

Tax Filer

The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect:

1. To file an income tax return for the Benefit Period
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Period;
3. That no other taxpayer will be able to claim him, her or them as a Tax Dependent for the Benefit Period; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her Spouse.

Telehealth

The delivery of services from a Provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile, or electronic mail.

Tier 1 Drugs

This tier includes low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier 2 Drugs

This tier includes preferred Drugs considered Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier 3 Drugs

This tier includes Drugs considered Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier 4 Drugs

This tier contains high cost Drugs. This includes Drugs considered Generic, single source Brand Drugs, and multi-source Brand Drugs.

Ultrasound

A radiology imaging technique that uses high frequency sound waves to see organs or the fetus in a pregnant woman.

Urgent Care

Care provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-Emergency).

Utilization Management

A process of integrating review of medical services and Care Management in a cooperative effort with other parties, including patients, Physicians, and other health care Providers and payers.

Utilization Review

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

We, Us, Our

Is Anthem.

X-ray and Radiology Services

Services including the use of radiology, nuclear medicine and Ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Year

A twelve (12) month period starting each January 1 at 12:01am Pacific Standard Time.

You and Your

The Subscriber and any family Members covered under this Certificate.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version: You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ ɓédé dyí-ɓèdèìn-dèɔ̀ ɓé m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé dé m̀ bídí-wùdùǔn ɓó pídyi. Đá méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̂ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka
Yin nŋ yic ba ye lëk në yök ku bë yi kuny në thöŋ yin jäm ke cin wëu töu kë piiny. Cl rän töŋ dë kc kë lui në nämba dën t në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、ID カードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើបណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Nepali
तपाईले यो जानकारी तथा सहयोग आफ्नो भाषामा नःशुल्क प्राप्त गर्ने तपाईको अधिकार हो। सहायताको लागि तपाईको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Avei dreptul să obinei aceste informaii i asistenă în limba dvs. în mod gratuit. Pentru asistenă, apelai numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)۔

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì èrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Anthem BlueCross BlueShield

Subscriber and Premium Information

Issued by:

Anthem

PLAN NAME:_____

CONTRACT CODE:_____

SUBSCRIBER'S NAME:_____

DEPENDENT'S NAME:_____

DEPENDENT'S NAME:_____

DEPENDENT'S NAME:_____

SUBSCRIBER'S RESIDENTIAL ADDRESS:_____

MONTHLY PREMIUM RATE:_____

PREMIUM RATE EFFECTIVE DATE:_____

Please review this information carefully and if it is incorrect please inform Your agent or Us immediately.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.