Anthem

Individual Market

Silver PPO Standard Pathway 87% CSR

Schedule of Benefits

Non-Tiered Network Plan

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Plan Deductible **Individual**	$650 per Member	$8,600 per Member
Family	$1,300 per family	$17,200 per family
Separate Prescription Drug Deductible **Individual**	$50 per Member	$500 per Member
Family	$100 per family	$1,000 per family
Out-of-Pocket Maximum **Individual**	$2,725 per Member	$17,200 per Member
Family **(includes Deductibles, Copayments and Coinsurance)**	$5,450 per family	$34,400 per family

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Provider Office Visits		
Adult/Pediatric Preventive Visits	No Cost	40% Coinsurance per visit
Primary Care Provider Office Visits (includes services for illness, injury, follow-up care and consultations)	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Mental Health and Substance Abuse Office Visit (including in-person and/or Virtual Visits)	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Outpatient Diagnostic Services (Please see the "Diagnostic Services" and "Preventive Care" sections of this Subscriber Agreement for additional information.)		
Advanced Radiology (CT/PET Scan, MRI)	$60 Copayment per service Up to a combined annual maximum of $360 for MRI and CAT scans; **$**400 for PET scans.	40% Coinsurance per service after OON plan Deductible is met
Laboratory Services	$10 Copayment per service	40% Coinsurance per service after OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic, non-preventive Breast Tomosynthesis)	$30 Copayment per service after INET plan Deductible is met	40% Coinsurance per service after OON plan Deductible is met
Non-preventive Mammography Ultrasound	$20 Copayment per service	40% Coinsurance per service after OON plan Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Retail Pharmacy **(30 day supply per Prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$10 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$25 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$40 Copayment per prescription after the INET prescription drug Deductible is met	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 4 Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $60 per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Prescription Drugs-Mail Order Pharmacy **(90 day supply per prescription supplied by an In-Network Pharmacy)** **(30 day supply per Prescription supplied by an Out-of-Network Pharmacy)** **Specialty Drugs** are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).		
Tier 1 Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.	$30 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 2 Tier 2 Drugs have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred Drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$75 Copayment per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 3 Tier 3 Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	$120 Copayment per prescription after INET prescription drug Deductible is met	40% Coinsurance per prescription after OON prescription drug Deductible is met
Tier 4 Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.	20% Coinsurance per prescription after INET prescription drug Deductible is met up to a maximum of $60 per prescription	40% Coinsurance per prescription after OON prescription drug Deductible is met
Outpatient Rehabilitative and Habilitative Services		

Benefit	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Speech Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, speech, and occupational therapies, separate 40 visits per Calendar Year limit combined for Habilitative speech, physical and occupational therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Physical and Occupational Therapy (40 visits per Calendar Year limit combined for Rehabilitative physical, occupational, and speech therapies, separate 40 visits per Calendar Year limit combined for Habilitative physical, occupational and speech therapies. The limits do not apply to Mental Health and Substance Abuse conditions.)	$20 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Other Services		
Chiropractic Services (up to 20 visits per Calendar Year)	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Diabetic Equipment and Supplies Diabetic supplies are covered under the Pharmacy benefit, please see the “Prescription Drug” section for details.	40% Coinsurance per equipment or supply	40% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	40% Coinsurance per DME item	40% Coinsurance per DME item after OON plan Deductible is met
Home Health Care Services **(up to 100 visits per Calendar Year)**	No Cost	25% Coinsurance per visit after separate $50 Deductible is met
Outpatient Services **(in a Hospital or ambulatory Facility)**	$100 Copayment per visit after INET plan Deductible is met at an Outpatient Hospital Facility $60 Copayment per visit after INET plan Deductible is met at an Ambulatory Surgery Center	40% Coinsurance per visit after OON plan Deductible is met
Inpatient Hospital Services		

Inpatient Hospital services (including mental health, substance abuse, maternity, hospice, Skilled Nursing Facility* and all IP settings.) *(Skilled Nursing Facility stay is limited to 90 days per Calendar Year)	$100 Copayment per day to a maximum of $400 per Admission after INET plan Deductible is met	40% Coinsurance per Admission after OON plan Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost	Same as In-Network
Emergency Room	$150 Copayment per visit after INET plan Deductible is met	Same as In-Network
Urgent Care Centers	$35 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met
Pediatric Dental Care (for children under age 26)		
Diagnostic & Preventive	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Basic Services	40% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Major Services	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit	50% Coinsurance per visit after OON plan Deductible is met
Pediatric Vision Care (for Dependent children under age 26)		
Prescription Eye Glasses **(one pair of frames and lenses or contact lens per Calendar Year)**	Lenses: $0 Collection Frame: $0 Non-collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered

Routine Eye Exam by Specialist **(one exam per Calendar Year)**	$45 Copayment per visit	40% Coinsurance per visit after OON plan Deductible is met

Important Notices about Your Benefits and Cost Shares

Connecticut State Mandate requires the Coinsurance for artificial limbs and accessories cannot exceed 20%. Please refer to the Artificial Limbs provision under the "Medical Supplies, Durable Medical Equipment and Appliances" section.

Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:

- an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
- covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe used to prevent or treat diabetes or low blood sugar. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.
- For HSA Plans certain diabetic supplies may apply the deductible.

When you get a 90-day supply, three 30-day Copayments will apply.

Covered Dental Services pediatric dental services are covered for Members until age 26. Pediatric Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see "Pediatric Dental Care" in the "What is Covered" section for more information on pediatric dental services.

Emergency Room Copayment A Member does not have to pay Emergency room Copayments if the Member is admitted directly to the Hospital from the Emergency room.

Hearing Aid Coverage available one per ear every 24 months.

Home Delivery Prescription Drugs tier 4 drugs are limited to a 30 day supply.

Medical Chat Covered Services accessed through Our mobile app may be provided at a lower cost. Services include speaking with a healthcare professional via text or chat, checking symptoms and more.

Mental Health and Substance Abuse Office Visit includes in home treatment.

Nonemergency Ambulance Services Benefits for nonemergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Nutritional Counseling two visits per Calendar Year.

Outpatient Habilitative and Rehabilitative Therapy Services limits on Physical, Occupational and Speech Therapy services listed above are not combined but separate based on determination of Habilitative service or Rehabilitative service.

Preventive Services- Federal Websites Please see the "Preventive Care Services" section of this Subscriber Agreement for more information or You may call Member Services at the number on Your Identification Card for more details about Preventive Care 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.

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

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

Retail Health Clinics subject to PCP Copay. All Inclusive; all services done during visit are covered under the Copayment.

Specialty Drugs are limited to a 30 day supply. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Unrelated Donor Searches when approved by Anthem, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants for up to 10 best matched donors performed by an authorized and licensed registry for a Covered Transplant Procedure.

Pediatric Vision benefits are covered for Dependent children until age 26. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, You must use a Blue View Vision Provider. For help finding one, try "Find a Doctor" on Our website or call the number on Your ID Card.

Pediatric Vision: Collection Contact Lenses You may use Your lens benefit to get eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options every Calendar Year. Collection Non-Elective or Elective Contact Lenses, please see the "Pediatric Vision Care" section of Your Schedule of Benefits for Cost Shares.

Pediatric Vision: Non-Collection Frames / Contact Lenses If You choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, You will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the Provider and Us. Claims for a non-collection frame / contact lenses must be submitted directly to Us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail Your complete claim form to the following address, along with the original itemized paid receipt that identifies the frame / contact lenses to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Urgent Care Center services received from a BlueCard® Provider will be covered at the In-Network level.

Urgent Care Center services received from a non-BlueCard® Provider will be covered at the Out-of-**Network level.**

All non-urgent services (BlueCard® or non-BlueCard®) will be covered at the Out-of-Network level.

The Home Health Care 100 visit limit is a combined In and Out-of-Network visit limit.

Subscriber Agreement

Silver PPO Standard Pathway 87% CSR

Right to Examine

If this Subscriber Agreement is provided to You as a Subscriber, You are permitted to return this Subscriber Agreement by delivering or mailing it to the agent or broker through whom it was purchased, or to Anthem at Our Home Office in Wallingford, Connecticut within 10 days after the date of delivery if, after examination of the Subscriber Agreement, You are not satisfied with it for any reason. If You return this Subscriber Agreement, it will be deemed void from the beginning and any and all claims paid will be retracted and any Premiums paid will be refunded. This right to examine the Subscriber Agreement does not apply at renewal.

Read Your Policy Carefully. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is therefore, important that You **READ YOUR POLICY CAREFULLY!**

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.)

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 Subscriber Agreement to give a clear description of Your benefits, as well as Our rules and procedures.

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

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

Many words used in the Subscriber Agreement 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 Subscriber Agreement 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.

Should You have a complaint, problem or question about Your health Plan or any services received, a Member Services representative will assist You. Contact Member Services by calling the number on the back of Your Member 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!

Identity Protection Services

Identity protection services are available with Our Anthem health Plans. To learn more about these services, please visit https://anthemcares.allclearid.com/.

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 Member Services address is:

Anthem Blue Cross and Blue Shield
Member Services
P.O. Box 1030
North Haven, Connecticut 06473

Visit Us on-line
www.anthem.com

Home Office Address

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

Hours of operation
Monday – Friday
8:00 a.m. to 5:00 p.m. Eastern Time

Conformity with Law

If State of Connecticut or federal laws that affect the meaning of any term or provision contained in this Subscriber Agreement are revised, the provisions of this Subscriber Agreement will automatically change to comply with those laws as of their Effective Dates. Any provision that does not conform with applicable

federal laws or the relevant laws of the State of Connecticut will not be rendered invalid, but will be construed and applied as if it were in full compliance.

Acknowledgement of Understanding

The Member hereby expressly acknowledges their understanding that this Subscriber Agreement constitutes a contract solely between Member and Anthem Blue Cross and Blue Shield, 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 Connecticut, and that Anthem is not contracting as the agent of the Association. Member further acknowledges and agrees that it has not entered into this Subscriber Agreement 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 Member for any of Anthem's obligations to Member created under this Subscriber Agreement. 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 Subscriber Agreement for each Subscriber.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in Our network and who is available to accept You or Your family Members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to Our website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (OBGYN) Care

You do not need prior authorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in Our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to Our website, www.anthem.com.

TABLE OF CONTENTS

HOW YOUR COVERAGE WORKS

The purpose of this section is to help You understand how to receive the highest level of benefits available under this Plan. It provides details about In-Network Providers who have entered into an agreement with Anthem and Out-of-Network Providers who have not. You will also find information about how to access a list of In-Network Providers in Your service area and the importance of choosing a Primary Care Physician.

To find an In-Network Provider for this Plan, please see “How to Find a Provider in the Network” later in this section.

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 Coinsurance. If You use an Out-of-Network Provider, You will have to pay more Out-of-Pocket costs unless Your care involves Emergency Care, ambulance services related to an Emergency for transportation to a Hospital.

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

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. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians and gynecologists, geriatricians or other In-Network Providers as allowed by Us. The PCP is the Doctor who may provide, coordinate, and arrange Your healthcare services. SCPs are In-Network Doctors who provide specialty medical services not normally provided by a PCP.

A consultation with an In-Network healthcare Provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

For services rendered by In-Network Providers:

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

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

If You receive Covered Services from an Out-of-Network Provider after We failed to provide You with accurate information in our Provider Directory, or after We failed to respond to Your telephone or web-based inquiry within the time required by federal law, Covered Services will be covered at the In-Network level.

Out-of-Network Services

When You do not use an In-Network Provider, Covered Services are covered at the Out-of-Network level, unless Your care involves Emergency Care, ambulance services related to an Emergency for transportation to a Hospital.

For services from an Out-of-Network Provider:

1) In addition to any Deductible and/or Coinsurance/Copayments, the Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount except for Surprise Billing Claims;
2) You may have higher Cost Sharing amounts (i.e., Deductibles, Coinsurance, 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.

How to Find a Provider in the Network

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

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's Network.
- Search for a Provider in Our mobile app, website, or Anthem-enabled devices. Details on how to download the app can be found on Our website, www.anthem.com.
- Contact Member Services to ask for a list of Doctors and Providers that participate in this Plan's Network based on specialty and geographic area.
- Check with Your Doctor or Provider.

If You need details about a Provider's license or training or 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.

You do not need a referral to see a Specialty Care Physician. You can visit any In-Network Specialist including a behavioral health Provider without a referral from a Primary Care Physician.

Primary Care Physician (PCP)

The Primary Care Physician (PCP) is a Doctor who can provide initial care, basic medical services and can be responsible for ongoing patient care. PCPs are usually internal medicine Doctors, family practice doctors, general practitioners, pediatricians, or obstetricians/gynecologists (OB/GYNs). As Your first point of contact, the PCP gives a wide range of healthcare services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care.

Selecting a Primary Care Physician (PCP)

Your Plan requires You to select a Primary Care Physician from Our Network, or We will assign one. We will notify You of the PCP that We have assigned. You may then use that PCP or choose another PCP from Our Provider Directory. Please see "How to Find a Provider in the Network" for more details.

You have direct access for Medical Chats and Virtual Visits with Our online partners through Our mobile app.

PCPs include family practitioner, pediatrician, internist, obstetrician/gynecologist (OB/GYN), qualified certified nurse practitioners or other qualified Primary Care Physicians, as required by law, for services within the scope of their license. 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, contact Us or refer to Our website, www.anthem.com.

The First Thing To Do – Make an Appointment With Your PCP

Your PCP's job is to help You stay healthy, not just treat You when You are sick. After You choose a PCP, make an appointment with Your PCP. During this appointment, get to know Your PCP and help Your PCP get to know You. At Your first appointment, talk to Your PCP about:

- Personal health history.
- Family health history.
- Lifestyle.
- Any health concerns You have.

It is important to note, if You have not established a relationship with Your PCP, they may not be able to effectively treat You. 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 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.

Connect with Us Using Our Mobile App

As soon as You enroll in this Plan, You should download Our mobile app. You can find details on how to do this on Our website, www.anthem.com.

Our goal is to make it easy for You to find answers to Your questions. You can chat with Us live in the app, or contact Us on Our website, www.anthem.com, or through an Anthem-enabled device.

Dental Providers

You do not have to select a particular dentist to receive dental benefits. You can choose any dentist You want for Your dental care. However, Your dentist choice can make a difference in how benefits are covered and how much You will pay out-of-pocket. You may have more out-of-pocket costs if You use a dentist that is 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 1-800-627-0004 for help in finding an In-Network dentist or visit Our website at www.anthem.com. Please refer to Your ID Card for the name of the dental program that In-Network Providers have agreed to service when You are choosing an In-Network dentist.

Continuity of Care

If Your In-Network Provider leaves Our Network for any reason other than termination for 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 Doctor or healthcare Provider attests that discontinuing care by the current Doctor or Provider would worsen Your condition or

interfere with anticipated outcomes. An “ongoing course of treatment” includes treatments for Mental Health and Substance Abuse 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.

Identification Card

When You receive care, You must show Your Identification Card. Only a Member who has paid the

Premiums under this Subscriber Agreement has the right to services or benefits under this Subscriber Agreement. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Subscriber Agreement, he/she is responsible for the actual cost of the services or benefits.

After Hours Care

If You need 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 Your condition is an Emergency, You should be taken to the nearest appropriate medical Facility. In the event of an Emergency call 911.
- Your coverage includes benefits for services rendered by Providers other than In-Network Providers when the condition treated is an Emergency, as defined in this Subscriber Agreement.

Relationship of Parties (Anthem and In-Network Providers)

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

Your healthcare 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.

REQUESTING APPROVAL FOR BENEFITS

Your Subscriber Agreement includes the process of Utilization Review to decide when services are Medically Necessary or Experimental or Investigational as those terms are defined in this Subscriber Agreement. Utilization Review aids in the delivery of cost-effective healthcare by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service unless otherwise required by law. 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 place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical Facility, or in a Doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If You have any questions about the Utilization Review process, the medical policies or clinical guidelines, 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 Subscriber Agreement;
4. The service cannot be subject to an Exclusion under Your Subscriber Agreement; and
5. You must not have exceeded any applicable limits under Your Subscriber Agreement.

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 Subscriber Agreement.

      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. For labor / childbirth

admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

- **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. 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. 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. However, You may request a Precertification, 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 not to 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 not to be Medically Necessary. • **BlueCard® Provider must obtain Precertification for all Inpatient admissions.**
NOTE: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible.		

Services Requiring Review

Services for which Precertification is required (i.e., services that need to be reviewed by Us to determine whether they are Medically Necessary) include, but are not limited to, the following:

- All elective/scheduled Inpatient Hospital admissions;
- Inpatient and Outpatient Facility treatment for Mental Health and Substance Abuse Services, such as:
    - Residential Treatment,
    - Partial Hospitalization Program (PHP),
    - Intensive Outpatient treatment programs (IOP),
    - Intensive in-home services,
- Skilled Nursing Facility and Inpatient Rehabilitation stays;
- Transcranial Magnetic Stimulation (TMS);
- Human Organ and Bone Marrow/Stem Cell/Cord Blood transplant services (with or without myeloablative therapy) donor leukocyte infusion, and donor search services;
- Chimeric Antigen Receptor Therapies (CAR T)
- Specialty Drugs and related services in any setting, including, but not limited to: Doctor's office, infusion center, Outpatient Hospital or clinic, or Your home or other residential setting;
- Specific surgical procedures, wherever performed, or the site of surgical procedures, as specified by Us; e.g., gastric bypass surgery;
- All elective hip, knee, and shoulder arthroscopic/open sports medicine, outpatient spine surgery and interventional spine pain procedures
- Specific diagnostic procedures, including advanced imaging procedures, wherever performed, such as:
    - Computerized Tomography (CT)
    - Computerized Tomography Angiography (CTA)
    - Magnetic Resonance Imaging (MRI)
    - Magnetic Resonance Angiography (MRA)
    - Magnetic Resonance Spectroscopy (MRS)
    - Nuclear Cardiology (NC)
    - Nuclear technology
    - Positron Emission Tomography (PET)
    - PET and PET/CT Fusion
    - SPECT

    - QTC Bone Densitometry
    - Diagnostic CT Colonography
    - Echocardiogram
- Polysomnography and home portable monitors ;
- Specialized durable medical equipment– customized equipment;
- Ambulance (Air / Water) services for nonemergency transfers;
- Therapy Services, wherever performed, such as:
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy
    - Autism Services
    - Radiation Therapy
- Transgender services;
- Genetic testing;
- Skilled nursing services in the home;
- Infertility Services;
- Specialized Formula.

For a list of current procedures, or the site of surgical procedures, requiring Precertification, please call the toll-free number for Member Services printed on Your Identification Card.

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 Subscriber Agreement 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	48 hours from the receipt of the request, or 72 hours from receipt of the request if any portion of 48 hours period falls on a weekend
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 and no previous authorization exists	24 hours from the receipt of the request, We may request additional information within the first 24 hours and then extend to 72 hours
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	48 hours from the receipt of the request, or 72 hours from receipt of the request if any portion of 48 hours period falls on a weekend
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

Request for Mental Health and Substance Abuse Services	
Pre-service Urgent – levels of care include: Inpatient services, residential treatment, Partial Hospitalization, or intensive Outpatient programs.	24 hours from the receipt of the request
Pre-service/ non-Urgent – Outpatient services	15 calendar days from the receipt of the request
Continued stay/concurrent review Urgent	24 hours from the receipt of the request
Continued stay/concurrent review non-Urgent	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

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including Utilization Review, case management, and disease management) and/or offer an alternative benefit if, in Anthem's discretion subject to the other terms of this Subscriber Agreement, 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 Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or modify any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line precertification 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 Review 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

We have a range of programs designed to provide and/or help coordinate services for Members with healthcare needs due to serious, complex, and/or chronic health conditions (the "Program(s)"). Our Programs provide certain services, coordinate benefits and/or educate Members who agree to take part in them to help meet their health-related needs.

Our 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 Anthem and 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 healthcare needs. This is reached through contact and team work with You and, as appropriate, Your chosen authorized representative, treating Doctor(s), and other Providers.

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

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

WHAT IS COVERED

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

Please read the following sections of this Subscriber Agreement 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 Center, 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

Accidental Consumption or Ingestion

Benefits are provided for services associated with accidental consumption or ingestion of a controlled drug or other substance.

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are covered when:

- You are transported by a State licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation;

And one or more of the following are met:

- 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 Facility that can give care for Your condition. The ambulance medical professionals will transport you the emergency Facility best suited to provide you care at the time of services, regardless if they are In or Out-of-Network.

Benefits also include Medically Necessary treatment of a sickness or an injury by medical professionals during 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 except for Surprise Billing Claims.

Ground Ambulance

Services are subject to Medical Necessity review by Us.

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 except in an Emergency. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for nonemergency 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

Autism Services: Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs), identified and ordered in accordance with a treatment plan developed by a licensed Doctor, licensed psychologist or licensed clinical social worker pursuant to a comprehensive evaluation are covered as prescribed by State law as follows.

- Behavioral Therapy for children up until their 21st birthday, when provided or supervised by a licensed behavior analyst, a licensed Physician, or a licensed psychologist.
- Direct psychiatric or psychological services and consultations provided by a licensed psychiatrist or psychologist.
- Occupational, physical and speech/language therapy provided by a licensed therapist.

This occupational, physical and speech/language therapy benefit is not subject to any benefit maximum for Outpatient rehabilitative therapy listed in Your Schedule of Benefits. There is no coverage for special education and related services, except as described above.

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 Subscriber Agreement. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

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

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

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 Subscriber Agreement.

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.

Hospitalization for routine patient care costs shall include treatment at an Out-of-Network Facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Out-of-Network Hospitalization will be rendered at no greater Cost Share to the Member than if such treatment was available In-Network, all applicable In-Network Cost Shares will apply.

Inpatient and Outpatient Hospital Dental Services

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

Diabetes Services

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

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

- Medically Necessary;
- Ordered in writing by a Doctor or a podiatrist; and
- Provided by a Healthcare Professional who is licensed, registered, or certified under State law.

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

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

Outpatient Self-management Training

Outpatient self-management training for the treatment of diabetes including medical nutrition therapy, is covered if prescribed by a licensed healthcare professional and performed by a certified, licensed or registered healthcare professional trained in diabetes care and operating within the scope of their licensure. Benefits are provided for 10 hours of initial training, four hours of additional training because of changes in the individual’s condition and four hours of training required by new developments in the treatment of diabetes. Please refer to Your directory for a listing of Participating Providers and Hospitals where Covered Services may be obtained.

Note: Screenings for gestational diabetes are covered under “Preventive Care”.

Retina Exam for Diseases and Abnormalities of the Eye

Benefits are provided for an annual exam for Members with glaucoma or diabetic retinopathy.

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 (Certain breast ultrasounds are covered under the “Preventive Care” benefit. Please see that section for details).
- Electrocardiograms (EKG).
- Electroencephalography (EEG).
- Echocardiograms.
- Breast Tomosynthesis
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care).
- Tests ordered before a surgery or admission.

Advanced 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) (Certain MRI’s of the breast or breasts are covered under the “Preventive Care” benefit. Please see that section for details);
- 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.

Virtual Visits

Covered Services include virtual Telemedicine/Telehealth visits that are appropriately provided through the internet via video, chat or voice. This includes visits with Providers who also provide services in person, as well as online-only Providers.

- **Medical Chats** Covered Services accessed through Our mobile app with a doctor via a text message or chat for limited medical care.
- **"Telemedicine/Telehealth"** means the delivery of healthcare or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing; or secure instant messaging through Our mobile app, website, or Anthem-enabled devices; interactive store and forward (asynchronous) technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a healthcare Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.
- **Specialist e-Consultations** are electronic communications between Your PCP, who is rendering care to You, and an In-Network Specialist to help evaluate Your condition or diagnosis. The consultation will be at no cost to You. Your PCP may consider the information provided by the In-Network Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies and the results may be documented in an electronic health record.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

If You have any questions about this coverage, please contact Member Services at the number on the back of Your Identification Card.

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 healthcare services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Healthcare services are typically given by physician 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.

Nutritional Counseling for illnesses requiring therapeutic dietary monitoring, including the diagnosis of obesity.

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

Medically Necessary Pain Management medication and procedures when ordered by a pain management Specialist.

Blood lead screenings and clinically indicated risk assessments when ordered by a PCP.

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

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

Habilitative Services are healthcare services and devices that help You keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not 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 Healthcare Services

Benefits are available for Covered Services performed by a Home Health Care Agency, advanced practice registered nurse 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 or an Advanced Practice Registered Nurse (APRN) within seven days following discharge of Inpatient services for the same or a related condition for which the covered person was hospitalized 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 healthcare professional, including nursing services by an R.N; or L.P.N., a therapist, or home health aide;
- Infusion Therapy; refer to “Therapy Services Outpatient”, 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 healthcare 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 healthcare Provider;
- Medical supplies;
- Durable medical equipment;
- Therapy 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.
- Skilled nursing services and home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies.

In order to receive hospice benefits (1) Your Doctor and the hospice medical director must certify that You are terminally ill and have approximately 12 months to live, and (2) Your Doctor must consent to Your care by the hospice and must be consulted in the development of Your treatment plan. You may access hospice care while also participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness. The hospice must maintain a written treatment plan on file and furnish to Us upon request.

Covered Services beyond those listed above as ordered by Your treating Provider, may be available while in hospice and are detailed in other sections of this Subscriber Agreement.

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. If the newborn needs services other than routine nursery care or stays in the Hospital after the mother's discharge, benefits for the newborn will be treated as a separate admission;
- 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 Subscriber Agreement 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 (if the newborn needs services other than routine nursery care or stays in the Hospital after the mother's discharge, benefits for the newborn will be treated as a separate admission.);
- 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.

Please see "Continuity of Care" in the "How Your Coverage Works" section regarding a request to continue to see the same Provider for services.

Post-delivery Care Home Visit

Covered Services include a follow-up home visit within 48 hours following You and Your newborn child's discharge from the Hospital and an additional follow-up visit within seven days.

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.

Infertility Services

Covered infertility services include the following when prior authorization is received;

- Ovulation induction coverage is limited to a lifetime maximum of four cycles;
- Intrauterine insemination is limited to a lifetime maximum of three cycles; and
- In-vitro, GIFT, ZIFT and low tubal ovum transfer is limited to a maximum of two cycles combined with not more than two embryo implantations per cycle-with each fertilization or transfer counting as one cycle.

Also included are infertility drugs for conditions with an infertility diagnosis.

Abortion Services

Coverage includes benefits for therapeutic and elective abortions.

Medical Supplies, Durable Medical Equipment and Appliances

Durable Medical Equipment and Medical Devices

Your Subscriber Agreement 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, purchase or rent-to-purchase equipment and devices, and continuous rental equipment and 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.

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 Doctor or licensed audiologist. Covered services include:

- Hearing Aids, including bone anchored hearing aids – Any wearable, nondisposable instrument or device designed to aid or compensate for impaired human hearing.

Prosthetics

Your Subscriber Agreement 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:

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

Artificial Limbs

Your Plan includes benefits for Artificial Limbs and accessories, including a Medically Necessary device that contains a microprocessor and repairs and replacements. Artificial Limbs are devices to replace, in whole or in part, an arm or a leg when they are Medically Necessary for activities of daily living.

Covered Services do not include:

- Artificial Limbs designed exclusively for athletic purposes;
- repair or replacement due to misuse or loss;
- back-up items or items that serve a duplicate purpose.

Medical and Surgical Supplies

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

Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Diabetic Equipment and Supplies

Your Plan includes coverage for insulin pumps and supplies.

Wound-Care supplies

Your Subscriber Agreement includes coverage for wound care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Doctor.

Blood and Blood Products

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

Blood Derivatives

Your Plan also includes coverage for blood derivatives when purchased through a blood derivative supplier.

Inherited Metabolic Diseases

Your Plan also includes coverage for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases including cystic fibrosis.

Specialized Formulas

Your Plan also includes coverage for specialized formulas when such specialized formulas are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Doctor.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that We must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and stabilization services.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment, such as detoxification and stabilization services, and includes:
    - Observation and assessment by a Doctor weekly or more often,
    - Rehabilitation and therapy.

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

    - The insured has a Medically Necessary, serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a Doctor, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, Partial Hospitalization, intensive Outpatient or Outpatient setting; and
    - An individual Treatment Plan must be prescribed by a Doctor with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.
    - Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

- **Outpatient Services** including office visits, therapy, treatment, evidence-based maternal, infant and early childhood home visitation services, detoxification and stabilization services, chemical maintenance treatment, Partial Hospitalization/day treatment programs, intensive Outpatient programs, intensive in-home behavioral health services, home-based therapeutic interventions for children, extended day treatments and observation beds in an acute Hospital setting.

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

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

  We Cover Outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including, but not limited to, Partial Hospitalization program services, Intensive Outpatient Program services, and methadone treatment. Such Coverage is limited to Facilities that are licensed or certified by a State agency and which are fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA), as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for Outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Doctors who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

- **Virtual Visits** as described under "Doctor (Physician) Visits" subsection.

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

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed or Certified Alcohol and Drug Counselor,
- Licensed professional counselor (L.P.C),
- Licensed advanced practice registered nurse, or
- Any agency licensed by the State to give these services, when We have to cover them by law.

Preventive Care Services

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

Certain benefits for Members who have current symptoms or a diagnosed health problem, may be covered under the "Diagnostic Services Outpatient" 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 and per Connecticut law;

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, but not limited to:

    - Contraceptive coverage includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Brand Drugs will be covered, as preventive care benefits when Medically Necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy".
    - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per pregnancy 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 obtained at a Retail or Home Delivery Pharmacy.
    - Nicotine replacement therapy products obtained at a Retail or Home Delivery Pharmacy 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
    - Bowel preparations

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

7. As required by State law the following Covered Services are considered preventive care services (HSA plans preventive care services are covered with no Copayments or Coinsurance, however Your Deductible may apply):

- Comprehensive Ultrasound screening of an entire breast or breasts if:
  - A mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or
  - A woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer,
  - positive genetic testing, or
  - Other indications as is recommended by a woman's treating Physician or advanced practice registered nurse, for a woman who;
    - is forty years of age or older, or
    - has a family history or prior personal history of breast cancer, or
    - has a prior personal history of breast disease diagnosed through biopsy as benign.
- Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

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

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

Rehabilitative Services

Rehabilitative Services are healthcare 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 Subscriber Agreement 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 Subscriber Agreement 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 Subscriber Agreement.

Note: This section does not apply to orthognathic surgery.

Breast Reconstruction Surgery Benefits and the Women's Health and Cancer Rights Act of 1998

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

- Reconstruction of the breast(s) on which a covered mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications related to all stages of a covered mastectomy, including lymphedema (swelling). Prior authorization is not applicable to such prostheses.

The manner in which services are provided is between You and Your Doctor. Coverage is subject to all terms and conditions stated in this Subscriber Agreement. Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in the Subscriber Agreement. You may be entitled to additional benefits as mandated by State law.

Following a mastectomy We will provide Inpatient Hospital services for at least 48 hours after the mastectomy or lymph node dissection unless otherwise agreed upon by the Member or Doctor.

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 Subscriber Agreement 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.

Early Intervention Services

Services from birth to age three for Medically Necessary early intervention. Covered Services for a Member and his/her family Members provided as part of an individualized family service plan. Payment of such services shall not be applied against annual limits specified in this Subscriber Agreement.

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. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **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. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **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** – Includes evaluation and treatment.

Transgender Services

Benefits are provided for many of the charges for transgender surgery (also known as sex reassignment surgery) for Members diagnosed with Gender Dysphoria. Transgender surgery must be approved by Us as Medically Necessary for the type of transgender surgery requested and must be authorized. Some conditions apply, and all services must be authorized by Us as outlined in the "Requesting Approval for Benefits" section.

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood

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

Covered Transplant Procedure

A covered transplant procedure is any Medically Necessary human organ and bone marrow/stem cell/cord blood 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.

The initial evaluation, any added tests to determine Your eligibility as a candidate for a transplant by Your Provider, and the collection and storage of bone marrow/stem cells are included in the covered transplant procedure benefit regardless of the date of service.

Unrelated Donor Searches

Your Plan includes Human Leukocyte Antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per transplant. The testing must be done at an accredited Facility.

When approved by Us, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell/cord blood transplants performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants for a covered transplant procedure. Donor search charges are limited to the 10 best matched donors, identified by an authorized registry.

Live Donor Health Services

Medically Necessary charges for the procurement, performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants, 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. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

Transplant Benefit Period

The transplant Benefit Period starts one day prior to a covered transplant solid organ procedure and one day prior to high dose chemotherapy or preparative regimen for bone marrow stem cell transplants 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 start on the day of the covered transplant procedure and continue to the date of discharge.

Prior Authorization 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.

Precertification is required before We will cover benefits for a transplant. Your Doctor must certify, and We must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for

Precertification to Us as soon as possible to start this process. Please see the "Requesting Approval for Benefits" section for how to obtain Precertification.

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. Travel costs for the donor are generally not covered, unless We make an exception and approve them in advance of the procedure. 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 bone marrow/stem cell/cord blood transplant services benefits or requirements described above do not apply to the following:

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

The above services are covered as Inpatient Services, Outpatient Services or Doctor Home Visits and Office Services depending where the service is performed and are 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

This section describes how You can obtain covered Prescription Drugs administered by a Medical Provider or through a Retail Pharmacy, Our Home Delivery Pharmacy, or Our Specialty Pharmacy. Please see the information below that describes how Prescription Drugs are covered.

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, Home Delivery or Specialty 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 Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

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

- Quantity, dose, and frequency of administration;
- Specific clinical criteria (including, but, not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease;)
- Specific Provider qualifications (including, but, not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies));
- Step therapy requiring one drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost effectiveness when clinically similar results may be anticipated (Any step therapy regimen shall be implemented consistent with applicable law);
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem which is a list of 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 Subscriber Agreement.

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 Pharmacy 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 Doctor about alternatives to certain prescribed drugs. We may contact You and Your Doctor to make You aware of these choices. Only You and Your Doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic drug substitutes, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy

Your Plan also includes benefits for Prescription Drugs You get at a Retail, Home Delivery or Specialty Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery 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.

Certain contracted Retail Pharmacies can fill Your Prescription at the same Cost Shares that apply to the Home Delivery Pharmacy level of benefits. Please ask Your Pharmacy if they offer this special arrangement or call Pharmacy Member Services at the phone number on Your ID Card for a list of Retail Pharmacies that offer the Home Delivery Pharmacy level of benefits.

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

Prior Authorization is the process of getting benefits approved before certain Prescriptions can be filled.

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, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated. (Any step therapy regimen shall be implemented consistent with applicable law);
- use of a Prescription Drug List (as described below).

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

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

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

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription 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;
- Continuous glucose monitoring systems and supplies;
- 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, Coinsurance, and/or Deductible that applies when You get the drug. If You do not have Your

Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

Note: If We determine that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of 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 Subscriber Agreement.

In addition, if We determine that You may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Providers for Controlled Substance Prescriptions may be limited. If this happens, We may require You to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if You use the single In-Network Provider. We will contact You if We determine that use of a single In-Network Provider is needed and give You options as to which In-Network Provider You may use. If You do not select one of the In-Network Providers We offer within 31 days, We will select a single In-Network Provider 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 Subscriber Agreement.

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 will not 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 Pharmacy 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 PBM's Specialty Pharmacy

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

Specialty Pharmacy Program

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

If You order Your Specialty Drug through the PBM's Specialty Pharmacy and it does not arrive, if Your Doctor 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 PBM's Specialty Pharmacy will coordinate the exception and You will not be required to pay additional Coinsurance.

Home Delivery Pharmacy

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

Maintenance Medication

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

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 Home Delivery program, You can call Pharmacy Member Services toll-free at 1-833-236-6196.

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

The first Home Delivery 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 Home Delivery 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 Home Delivery Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the Home Delivery Prescription Drug program including, but not limited to, antibiotics, drugs not on the Prescription Drug List, drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the Home Delivery Prescription Drug program Member Services department at 1-833-236-6196 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. .

- **Tier 1 Drugs** have the lowest Coinsurance or Copayment. This tier contains low cost and preferred drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
  Certain low cost drugs, on Tier 1, may be available to Members at no Cost Share. These drugs are listed on Our Prescription Drug List (formulary).
- **Tier 2 Drugs** have a higher Coinsurance or Copayment than those in tier 1. This tier may contain preferred drugs that may be single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 3 Drugs** have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred drugs that may be, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 4 Drugs** have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

Prescription Drug List

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

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

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

We retain the right, at Our discretion, to decide coverage based upon medication dosages, dosage forms, manufacturer and administration methods (i.e., oral, injected, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

This Plan limits Prescription Drug coverage to those Prescription Drugs listed on Our Prescription Drug List. This formulary contains a limited number of Prescription Drugs, and may be different than the formulary for other Anthem products. Benefits may not be covered for certain Prescription Drugs if they are not on the Prescription Drug List. Generally, it includes select Generic Drugs with limited Brand Drug coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. Inclusion of a drug or related item on the covered Prescription Drug List is not a guarantee of coverage. A description of the Prescription Drugs that are listed on this Prescription Drug List 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 Prescription Drug 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 Doctor 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. We will work with the Pharmacy to decide when this should happen.

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

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and Your Doctor about alternatives to certain prescribed drugs. We may contact You and Your Doctor to make You aware of these choices. Only You and Your Doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic drug substitutes, call Pharmacy 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. 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 Pharmacy Member Services number on Your Member ID card or log on to the Member website at www.anthem.com.

Special Programs

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

Rebate Impact on Prescription Drugs You Get at Retail or Home Delivery Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by You from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by You is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowable Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time You purchase the Prescription Drug, the amount the rebate applied to Your claim will be based on an estimate. Payment on Your claim will not be adjusted if the later determined rebate value is higher or lower than Our original estimate.

Claims and Member Services

For information and assistance, a Member may call or write Anthem. The telephone number for Pharmacy Member Services is printed on the Member's Identification Card.

The address of Anthem is:

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

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Home Office Address:

You may visit Our home office during normal business hours at:
108 Leigus Road, Wallingford, CT 06492

Drugs for which Prior Authorization is currently required are below. For a current list, visit our website at www.anthem.com.

abiraterone acetate oral tablet	acetaminophen-codeine oral tablet, solution	ACTIMMUNE SUBCUTANEOUS SOLUTION	adapalene external cream, gel
AFINITOR DISPERZ ORAL TABLET SOLUBLE	AFINITOR ORAL TABLET 10 MG	ALOCRIL OPHTHALMIC SOLUTION	alogliptin benzoate tablet
ALOMIDE OPHTHALMIC SOLUTION	alosetron hcl tablet	alyq oral tablet	ambrisentan oral tablet
AMNESTEEM ORAL CAPSULE	amoxicill-clarithro-lansopraz oral	amphetamine-dextroamphetamine er oral capsule extended release 24 hour	amphetamine-dextroamphetamine oral tablet
APIDRA	APOKYN	APTIVUS CAPSULE, ORAL SOLUTION	ARANESP INJECTION
ARCALYST SUBCUTANEOUS SOLUTION	aripiprazole solution, tablet	armodafinil tablet	ASCOMP-CODEINE CAPSULE
asenapine maleate sublingual tablet	aspirin-omeprazole oral tablet delayed release 325-40 mg	atomoxetine hcl capsule	AVANDIA TABLET 2 MG, 4 MG
AVITA EXTERNAL CREAM	BEPREVE OPHTHALMIC SOLUTION	BERINERT INTRAVENOUS KIT	bexarotene capsule
BIJUVA CAPSULE	bosentan tablet	BOSULIF TABLET	butalbital-acetaminophen-caffeine-codeine capsule
butalbital-aspirin-caff-	calcitriol capsule	calcitriol solution	capecitabine tablet

codeine capsule			
CAPRELSA TABLET	CARBAGLU TABLET	carisoprodol-aspirin-codeine tablet	celecoxib capsule
cheratussin ac syrup 100-10 mg/5ml	chlorpromazine hcl tablet	chlorpropamide oral 100 mg, 250 mg	CHOLBAM CAPSULE
chorionic gonadotropin intramuscular solution	cinacalcet hcl tablet	CLARAVIS CAPSULE 10 MG, 20 MG, 40 MG	claravis capsule 30 mg
clonidine hcl er tablet extended release 12 hour	CLOVIQUE CAPSULE	clozapine tablet	clozapine tablet dispersible
codeine sulfate tablet	colchicine capsule	COMETRIQ KIT	CONSENSI TABLET
COREMINO TABLET EXTENDED RELEASE 24 HOUR	COSENTYX SENSOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR	COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	DALIRESP TABLET
dapsone external gel 5 %	darifenacin hydrobromide er tablet extended release 24 hour	deferiprone tablet	DENAVIR EXTERNAL CREAM
DEXILANT CAPSULE DELAYED RELEASE	dexmethylphenidate hcl er capsule extended release 24 hour	dexmethylphenidate hcl tablet	dextroamphetamine sulfate er capsule extended release 24 hour
dextroamphetamine sulfate solution, tablet	diclofenac epolamine external patch	diclofenac epolamine transdermal patch 1.3 %	diclofenac sodium external gel 3 %
diclofenac sodium transdermal gel 3 %	diclofenac-misoprostol tablet delayed release	DIFICID TABLET	dihydroergotamine mesylate nasal solution
doxepin hcl tablet	doxercalciferol capsule	doxycycline hyclate tablet delayed release 100 mg, 150 mg, 75 mg	DUEXIS TABLET
EDURANT TABLET	EMADINE OPHTHALMIC SOLUTION 0.05 %	EMBEDA CAPSULE EXTENDED RELEASE	EMCYT CAPSULE
ENBREL MINI	ENBREL INJECTION	ENBREL SURECLICK	EPCLUSA TABLET
ERBITUX INTRAVENOUS SOLUTION	ERIVEDGE CAPSULE	erlotinib hcl tablet	ERTACZO EXTERNAL CREAM
eszopiclone tablet 3 mg	everolimus tablet	EXTAVIA SUBCUTANEOUS KIT	ezetimibe tablet
ezetimibe-simvastatin tablet	FANAPT TABLET, TITRATION PACK	FARXIGA TABLET	FARYDAK CAPSULE
febuxostat tablet	fentanyl transdermal patch 72 hour	FERRIPROX TABLET 1000 MG	FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED

flucytosine capsule	flunisolide nasal solution	fluorouracil external cream 5 %, external solution	fluphenazine hcl concentrate
fluphenazine hcl elixir, tablet	FORTEO	FOSRENOL PACKET	frovatriptan succinate tablet
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED	g tussin ac solution	GILENYA CAPSULE 0.5 MG	GILOTRIF TABLET
glatiramer acetate subcutaneous solution prefilled syringe	GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	GLEOSTINE CAPSULE	glimepiride tablet
glipizide er tablet extended release 24 hour	glipizide tablet	glipizide xl tablet extended release 24 hour	glipizide-metformin hcl tablet
glyburide tablet	glyburide-metformin tablet	guaiatussin ac syrup	guaifenesin ac syrup
guaifenesin-codeine solution	guanfacine hcl er tablet extended release 24 hour	haloperidol decanoate intramuscular solution	haloperidol tablet
HEXALEN CAPSULE 50 MG	HORIZANT TABLET EXTENDED RELEASE	HUMIRA INJECTION	HUMULIN R U-500
HYCAMTIN CAPSULE	hydrocod polst-cpm polst er suspension extended release	hydrocodone bitartrate er capsule extended release 12 hour	hydrocodone-homatropine syrup
hydromet syrup	hydromorphone hcl er tablet extended release 24 hour	HYQVIA SUBCUTANEOUS KIT	ibandronate sodium tablet
IBRANCE CAPSULE	icatibant acetate subcutaneous solution	ICLUSIG TABLET	imatinib mesylate tablet
IMBRUVICA CAPSULE, TABLET	imiquimod external cream 5 %	INCRELEX SUBCUTANEOUS SOLUTION	INLYTA TABLET
INTELENCE TABLET	itraconazole capsule	JAKAFI TABLET	JANUMET TABLET
JANUMET XR TABLET EXTENDED RELEASE 24 HOUR	JANUVIA TABLET	JARDIANCE TABLET	lapatinib ditosylate tablet
LASTACAFT OPHTHALMIC SOLUTION	LATUDA TABLET	LENVIMA CAPSULE THERAPY PACK	leuprolide acetate injection kit
levorphanol tartrate tablet	linezolid suspension, tablet	loxapine succinate capsule	LYNPARZA CAPSULE 50 MG, TABLET
MEKINIST TABLET	MENTAX EXTERNAL CREAM	METADATE ER TABLET EXTENDED RELEASE 20 MG	metaxalone tablet
METHADONE HCL	methadone hcl	METHADOSE TABLET	methylphenidate hcl er

INTENSOL CONCENTRATE	concentrate, solution, tablet, soluble tablet	SOLUBLE	(cd) capsule extended release
methylphenidate hcl er tablet extended release	methylphenidate hcl solution, tablet	metoclopramide hcl tablet dispersible	miglustat capsule
minocycline hcl er tablet extended release 24 hour	modafinil tablet	mometasone furoate nasal suspension	morphine sulfate er capsule, tablet
naftifine hcl external cream	NEULASTA ONPRO INJECTION	NEULASTA INJECTION	NEUPOGEN INJECTION
NEXAVAR TABLET	niacin er (antihyperlipidemic) tablet extended release	nitisinone capsule	NOXAFIL SUSPENSION
NUTROPIN AQ NUSPIN	ODOMZO CAPSULE	OFEV CAPSULE	olanzapine tablet, dispersible tablet
olanzapine-fluoxetine hcl capsule	olopatadine hcl ophthalmic solution	omega-3-acid ethyl esters capsule	OMNARIS NASAL SUSPENSION
ORENCIA INJECTION	ORFADIN CAPSULE 20 MG	OTEZLA TABLET, THERAPY PACK	oxandrolone tablet
oxiconazole nitrate external cream	OXISTAT EXTERNAL LOTION	oxycodone hcl er tablet er 12 hour abuse-deterrent	oxymorphone hcl er tablet extended release 12 hour
OZEMPIC INJECTION	paliperidone er tablet extended release 24 hour	palonosetron hcl intravenous solution	paricalcitol capsule
penicillamine tablet	perphenazine tablet	phenoxybenzamine hcl capsule	PICATO EXTERNAL GEL 0.015 %, 0.05 %
pimecrolimus external cream	pimozide tablet	pioglitazone hcl tablet	PLEGRIDY INJECTION
POMALYST CAPSULE	PROCENTRA SOLUTION	PROCRIT INJECTION SOLUTION	PROMACTA TABLET
promethazine vc/codeine syrup	promethazine-codeine solution, syrup	promethazine-phenyleph-codeine syrup	pyrimethamine tablet
QNASL	quetiapine fumarate er tablet extended release 24 hour	quetiapine fumarate tablet	quinine sulfate capsule
ramelteon tablet	REBIF INJECTION	REVLIMID CAPSULE	RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
risperidone m-tablet	risperidone solution, tablet, dispersible tablet	robafen ac solution 100-10 mg/5ml	SANDOSTATIN LAR DEPOT INTRAMUSCULAR KIT
sapropterin dihydrochloride tablet	sapropterin dihydrochloride tablet soluble 100 mg	sildenafil citrate tablet 20 mg	SIMPONI INJECTION
simvastatin tablet 80	sodium phenylbutyrate	SOMATULINE DEPOT	SPRYCEL TABLET

mg	tablet	SUBCUTANEOUS SOLUTION	
STELARA INJECTION	STIVARGA TABLET	sulconazole nitrate external solution	sumatriptan-naproxen sodium tablet
SUNOSI TABLET	SUTENT CAPSULE	SYMLINPEN	SYNAREL NASAL SOLUTION
SYNERA EXTERNAL PATCH	SYNJARDY TABLET	SYNJARDY XR TABLET EXTENDED RELEASE 24 HOUR	tacrolimus external ointment
tadalafil (pah) tablet	tadalafil tablet 2.5 mg, 5 mg	TAFINLAR CAPSULE	TARGRETIN EXTERNAL GEL
TASIGNA CAPSULE	temozolomide capsule	testosterone cypionate intramuscular solution	testosterone transdermal gel
THALOMID CAPSULE	thiothixene capsule	tolazamide tablet 250 mg, 500 mg	tolbutamide tablet
tolcapone tablet	tolvaptan tablet	tramadol hcl er (biphasic) tablet extended release 24 hour	tramadol hcl er tablet extended release 24 hour
tramadol hcl tablet 50 mg	TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED	TREMFYA INJECTION	treprostinil injection solution
tretinoin (emollient) external cream	tretinoin external cream	tretinoin external gel 0.01 %, 0.025 %	trientine hcl capsule
trifluoperazine hcl tablet	TRULANCE TABLET	TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR	TUZISTRA XR SUSPENSION EXTENDED RELEASE
vancomycin hcl capsule	VENTAVIS INHALATION SOLUTION	VIBERZI TABLET	VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR
VIIBRYD TABLET, STARTER PACK KIT	virtussin a/c solution	voriconazole suspension reconstituted	voriconazole tablet
VOTRIENT TABLET	VYVANSE CAPSULE, CHEWABLE TABLET	XALKORI CAPSULE	XARTEMIS XR TABLET EXTENDED RELEASE
XELJANZ TABLET	XEOMIN INTRAMUSCULAR SOLUTION RECONSTITUTED	XIFAXAN TABLET	XIGDUO XR TABLET EXTENDED RELEASE 24 HOUR
XIIDRA OPHTHALMIC SOLUTION	XTANDI CAPSULE	XYLON TABLET	ZALTRAP INTRAVENOUS SOLUTION
ZELBORAF TABLET	ZENATANE CAPSULE	ZENZEDI TABLET	zileuton er tablet extended release 12

			hour
ZILRETTA INTRA-ARTICULAR SUSPENSION RECONSTITUTED ER	ziprasidone hcl capsule	ZOLINZA CAPSULE	ZORTRESS TABLET 1 MG
ZYDELIG TABLET	ZYKADIA CAPSULE 150 MG		

Pediatric Dental Care

Your Dental Benefits. Pediatric dental care services are covered for Members until the Plan renewal date once they reach 26 years of age. 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 are appropriate.

Pretreatment Estimates. When You need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it is 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.

Important: If You opt to receive dental services or procedures that are not covered benefits under this Plan, a Participating dental Provider may charge You his or her usual and customary rate for such services or procedures. Prior to providing You with dental services or procedures that are not covered benefits, the dental Provider should provide You with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand Your coverage, You may wish to review Your Subscriber Agreement document.

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 Subscriber Agreement. See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

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

Radiographs (X-rays)

- Bitewings – one series per 12 months.
- Periapicals.
- Full mouth (complete series) or panoramic – one time per 36 months.

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

Fluoride Treatment including: topical application of fluoride or therapeutic fluoride varnish**.** For Covered Members with moderate to high risk of dental decay.

Sealants. Covered one time per tooth per 36 months. Covered for Members through age 14 on permanent molars only.

Space Maintainers and Recement Space Maintainers

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

Oral Hygiene Instructions. Covered one time per 12 months through age three.

Basic Restorative Services

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

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.

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

Basic Tooth Extractions

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

Surgical Incision and Drainage of an Abscess

Endodontic Services

Endodontic Therapy

- Therapeutic pulpotomy and pulpal therapy on primary teeth.
- Root canal (endodontic) therapy on permanent teeth.

Apexification. Coverage for this benefit includes all visits to complete the service.

Gingivectomy or Gingivoplasty. This is a surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Gingivectomy covered only for severe side effects caused by medicine.

Oral Surgery Services

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

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

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered when given with a 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. Nitrous oxide is covered for Members under eight years old, or for Members age eight and older that have been diagnosed with a behavioral problem.

Major Restorative Services

Permanent Crowns. 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 are responsible to pay for the difference plus any applicable Deductible and Coinsurance.

Prefabricated or Stainless Steel Crowns

Prosthodontic Services

Dentures and Partials (removable prosthodontic services).

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

Repairs and Replacement of Broken Clasps

Replacement of Broken Artificial Teeth. Covered as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once six months has passed from the initial placement of the appliance and the narrative from the treating dentist supports the service.

Recementation of Bridge (fixed prosthetic)

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, the condition scores at a level consistent with the need for 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 Subscriber Agreement.

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 Subscriber Agreement ends.

If Your orthodontic treatment is already in progress (the appliance has been installed) when You begin coverage under this Subscriber Agreement, 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 Subscriber Agreement. We will not pay for any portion of Your treatment that was given before Your Effective Date under this Subscriber Agreement.

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 Subscriber Agreement.

- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Pediatric Vision Care

These vision care services are covered for Dependent children until the plan renewal date once they reach 26 years of age. 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.

Important: If You opt to receive optometric services or procedures that are not covered benefits under this Plan, a Participating optometrist may charge You his or her usual and customary rate for such services or procedures. Prior to providing You with optometric services or procedures that are not covered benefits, the optometrist should provide You with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand Your coverage, You may wish to review your Subscriber Agreement document.

Routine Eye Exam

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

Eyeglass Lenses

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

Covered lenses include the following lens options at no additional cost when received In-Network: factory scratch coating, UV coating, standard polycarbonate, standard photochromic, standard anti-reflective coating, gradient tinting, and glass-grey #3 prescription sunglasses.

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;
- Anisometropia of 3D or more;
- For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Note: We will not pay for non-elective contact lenses for any Member who has 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 Subscriber Agreement. 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 Subscriber Agreement.

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 Subscriber Agreement.

The following services are not covered:

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; or
- the services are approved in advance by Us/Anthem.

Medical Services

Your Medical benefits do not cover:

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

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

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

Alternative/Complementary Medicine. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture (except when provided for pain management), holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy except as required by applicable law, 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 Doctor is not a Covered Service. Non-Covered Services for Ambulance include, but are not limited to, trips to:

- A Doctor'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 Doctor. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing Facility or a rehabilitation Facility, Doctor's office, or Your home.

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

Autopsies and Post-mortem Testing.

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

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

Breast Reduction/Augmentation. Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

Charges Not Supported by Medical Records. Charges for services not described in Your medical records.

Charges Over the Maximum Allowed Amount. Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims.

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

- Any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-investigational treatments; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- 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 as a Covered Service in this Subscriber Agreement.

Complications of Non-Covered Services. Services, supplies or treatment related to or, 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 Subscriber Agreement 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.

Compound Drugs.

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 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 Subscriber Agreement. 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 except as otherwise specified as a Covered Service in this Subscriber Agreement.

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

Cryopreservation Charges. Cryopreservation Charges associated with the Cryopreservation of eggs, embryos, or sperm, including freezing, storage, and thawing.

Custodial Care. Custodial Care, unless otherwise required by Federal or State law, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Braces. For Dental braces except as specified as a Covered Service in this Subscriber Agreement.

Dental Implants. For Dental implants except as specified as a Covered Service in this Subscriber Agreement.

Dental Treatment. For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Subscriber Agreement. “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 and Appliances. For Dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified as a Covered Service in this Subscriber Agreement . The only exceptions to this are for any of the following:

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

Diabetic equipment and supplies. Diabetic equipment and supplies including continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit. This does not include Insulin pumps and Insulin pump supplies.

Doctor or Other Practitioners' Charges. Doctor or other practitioners' charges including:

- 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 Doctor.
- For membership, administrative, or access fees charged by Doctors 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.

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

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.

Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Plan or 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 Prescribed by Providers lacking qualifications/registrations/certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.

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).

Durable Medical Equipment. Covered Services do not include Durable Medical Equipment except as specified as a Covered Service in this Subscriber Agreement. Non-Covered Services or supplies include, but are not limited to:

- Orthopedic shoes or shoe inserts, except as specified as a Covered Service in this Subscriber Agreement.
- Air purifiers, air conditioners, humidifiers.
- Exercise equipment, treadmills.
- Pools and spas.
- Elevators.
- Supplies for comfort, hygiene or beautification.
- Correction appliances or support appliances and supplies such as stockings.

Education/Training services. For services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

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 specified as a Covered Service in this Subscriber Agreement. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

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

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

Foot Care – Routine. For routine foot care except when Medically Necessary (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

Genetic Testing and Counseling. Benefits are not provided for genetic testing or genetic counseling except as specified as a Covered Service in this Subscriber Agreement.

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

Gynecomastia. For surgical treatment of gynecomastia.

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 Doctor. This exclusion also applies to health spas.

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

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements except as specified in the "What is Covered" section even if the food, meal, formula or supplement is the sole source of nutrition except as specified in "Diabetic Equipment and Supplies" in the "What is Covered" section of this Subscriber Agreement.
- 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.

Hyperhidrosis. For treatment of hyperhidrosis (excessive sweating).

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.

Maintenance Therapy. For maintenance therapy (excluding Habilitative services or services required by State or federal law.) 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.

Manipulation Therapy – Home. For Manipulation Therapy services rendered in the home except as specified as a Covered Service in this Subscriber Agreement.

Medical Chats Not Provided Through Our mobile app. Texting or chat services provided through a service other than Our mobile app, website, or Anthem-enabled devices.

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

Medicare Benefits. For which benefits are payable under Medicare Parts A, B and/or D, unless prohibited by law.

Mental Health and Substance Abuse Services. Your coverage does not include benefits for the following services:

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

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-approved drugs. Drugs not approved by the FDA unless We must cover the use by law or if We approve it.

Non Authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specified as a Covered Service in this Subscriber Agreement.

Nonemergency Care Received in Emergency Room. For care received in an Emergency Room that is not Emergency Care, except as specified as a Covered Service in this Subscriber Agreement. 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 specified as a Covered Service in this Subscriber Agreement or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

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

Oral Appliances for Snoring. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Outdoor Treatment Camps and/or 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, except as specified as a Covered Service in this Subscriber Agreement or as required by law.

Personal Care, Convenience and Mobile/Wearable Devices. 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 Doctor. 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;
- Consumer wearable/personal mobile devices (such as smart phone, smart watch, or other personal tracking devices), including any software or applications;
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails);
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

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

Private Duty Nursing. For Private Duty Nursing Services except as specified as a Covered Service in this Subscriber Agreement.

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 Subscriber Agreement, or recognized by Us.

Reconstructive Services. Reconstructive services except as specified as a Covered Service in this Subscriber Agreement, 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 as a Covered Service in this Subscriber Agreement.

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

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

Reversal of Sterilization. Sterilizations for men and reversals of sterilizations for men and women.

Routine Patient Care Costs shall not include:

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

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

Routine physical exams or immunizations at an Urgent Care Center**.**

Self-Help Training/Care. For self-help training and other forms of non-medical self care, except as specified as a Covered Service in this Subscriber Agreement.

Services Not Appropriate for Virtual Visits. Services that We determine require in-person contact and/or equipment that cannot be provided remotely.

Services Not Listed As Covered. Benefits are not provided for any service, procedure, or supply not listed as a Covered Service in this Subscriber Agreement.

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 Subscriber Agreement 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 specified as a Covered Service in this Subscriber Agreement 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 as specified as a Covered Service in this Subscriber Agreement.

Temporomandibular or Craniomandibular Joint Disorder. For the treatment of temporomandibular joint disorder, craniomaxillary disorder (except as covered under Your medical coverage) after "disorder or craniomandibular joint disorders and any treatment for jaw, joint or head and neck neuromuscular disorder. This includes all appliances.

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

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

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

- Child care.
- Mileage within the medical transplant Facility city.
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us.
- Frequent Flyer miles.
- Coupons, Vouchers, or Travel tickets.
- Prepayments or deposits.
- Services for a condition that is not directly related, or a direct result, of the transplant.
- 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.

Virtual Visits. Virtual Visits do not include the use of facsimile, texting (outside of Our mobile app), electronic mail, or non-secure instant messaging. Benefits also 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 Providers outside Our network, benefit Precertification or Provider to Provider discussions except as approved under the "What Is Covered" section.

Vision Orthoptic Training. For vision orthoptic training. This exclusion does not apply to Dependent children under the age of 26.

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

Weight Loss Programs. For weight loss programs, whether or not they are pursued under medical or Doctor supervision, except as specified as a Covered Service in this Subscriber Agreement. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

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 PBM.
- An allergenic extract or vaccine.
- Charges Not Supported by Medical Records Charges for Pharmacy services not related to conditions, diagnoses, and/or recommended medications described in Your medical records.
- 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.
- 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 specified in "Therapy Services Outpatient", or drugs specified in "Medical Supplies, Durable Medical Equipment and Appliances" in the "What is Covered" section – they are Covered Services.
- Drugs Not Approved by the FDA.
- Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Plan or 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 Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.
- 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 State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a Doctor.
- Drugs used for cosmetic purposes.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, glucose monitors.
- 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.

- Nutritional or Dietary Supplements Nutritional and/or dietary supplements, except as described in this Subscriber Agreement or that We must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over-the-counter and those You can get without a written Prescription or from a licensed pharmacist.
- Off label use. Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Onychomycosis Drugs. Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-counter drugs, devices or products, may not be Covered Services unless required by law.
- 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.
- Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- 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.

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 26 and older, except as specified as a Covered Service in this Subscriber Agreement.
- Dental services or healthcare services not specifically covered under the Subscriber Agreement (including any Hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, except as specified as a Covered Service in this Subscriber Agreement).
- 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 Subscriber Agreement.
- Biological tests for determination of periodontal disease or pathologic agents, except as specified as a Covered Service in this Subscriber Agreement.
- Collection of oral cytology samples via scraping of the oral mucosa, except as specified as a Covered Service in this Subscriber Agreement.
- 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).
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- 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.

- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- For dental services received prior to the Effective Date of this Subscriber Agreement or received after the coverage under this Subscriber Agreement has ended.
- Dental services given by someone other than a licensed Provider (dentist or Doctor) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), except as specified as a Covered Service in this Subscriber Agreement.
- Occlusal or athletic mouth guards.
- 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 Dependent children age 26 and older, except as specified as a Covered Service in this Subscriber Agreement.
- 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.
- 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 as a Covered Service in this Subscriber Agreement.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specified as a Covered Service in this Subscriber Agreement.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, except as specified as a Covered Service in this Subscriber Agreement.
- 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.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.

HOW YOUR CLAIMS ARE PAID

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.

Cost Sharing Requirements

Cost Sharing is how Anthem shares the cost of healthcare services with You. It means what Anthem is responsible for paying and what You are responsible for paying. You meet Your Cost Sharing requirements through Your payment of Copayments, Deductibles and/or Coinsurance (as described below).

Anthem works with Doctors, Hospitals, Pharmacies and other healthcare Providers to control healthcare costs. As part of this effort, most Providers who contract with Anthem agree to control costs by giving discounts to Anthem. Most other insurers maintain similar arrangements with Providers.

The contracts between Anthem and Our In-Network Providers include a “hold harmless” clause which provides that You cannot be held responsible by the Provider for claims owed by Anthem for healthcare services covered under this Subscriber Agreement.

Copayment

Copayment means the fixed dollar amount You may be responsible for when You visit a Provider or fill a prescription for covered Prescription Drugs at the Retail or Home Delivery Pharmacy. In some instances, a Copayment may be required before the Deductible for certain Covered Services. Your Copayment responsibility is shown in Your “Schedule of Benefits.” Whether a Copayment applies to a Covered Service, depends on Your Subscriber Agreement’s benefit design.

Copayments do not accumulate towards the Deductible, however Copayments satisfied in a Calendar Year accumulate towards the Out-of-Pocket Limit Maximum.

Coinsurance

Coinsurance means the percentage of the Maximum Allowed Amount for which You are responsible for a specified Covered Service. For example, if Your Coinsurance percentage listed on Your “Schedule of Benefits” is 20%, You are responsible for 20% of the Maximum Allowed Amount. See the explanation of Maximum Allowed Amount in this section for additional information. Whether a Coinsurance applies to a Covered Service depends on Your Plan’s benefit design.

Deductible

A Deductible is a specified dollar amount for Covered Services that the Member must pay within each Calendar Year before Anthem reimburses You for Covered Services. A Copayment may be required before the Deductible for certain Covered Services. The Deductible amount is listed in the “Schedule of Benefits” section. A new Deductible applies at the beginning of each Benefit Year.

Deductible Calculation

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

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

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

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

Out-of-Pocket Limit

The Out-of-Pocket Limit for Covered Services is the sum of the Deductible and Copayment/Coinsurance maximums paid in a Benefit Year. The Out-of-Pocket Limit is the most You pay for Covered Services in a Benefit Year. Once You meet Your Out-of-Pocket Limit, Anthem will cover 100% of the Maximum Allowed Amount for Covered Services for the rest of that Benefit Year.

Out-of-Pocket Limit Calculation

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

The individual Out-of-Pocket Limit applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year. No 1 person can contribute more than his or her individual Out-of-Pocket Limit.

Once the applicable In-Network Out-of-Pocket Limit 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 Limit is satisfied, no additional Cost Sharing will be required for the remainder of the Calendar Year, except for any charges over the Maximum Allowed Amount.

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

Out-of-Pocket Limit Exceptions

Please read this section very carefully. Not all money that You pay toward Your healthcare costs are counted toward Your Out-of-Pocket Limit.

Amounts You incur towards Your Deductible, Copayments and/or Coinsurance count towards the Out-of-Pocket Limit. However, the following will never count towards the Out-of-Pocket Limit, nor will they ever be paid under this Plan:

- Amounts exceeding the Maximum Allowed Amount;
- Amounts over any Plan maximum or limitation; and/or
- Expenses for services not covered under this Subscriber Agreement.

Services Received from Out-of-Network Providers

Covered Services that are not obtained from a PCP, SCP or another In-Network Provider, or that are not Authorized Services will be considered Out-of-Network. The only exceptions are Emergency Care, or Emergency ambulance services.

For services rendered by an Out-of-Network Provider, You are responsible for:

- The difference between the actual charge and the Maximum Allowed Amount except for Surprise Billing Claims, plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non-Covered Services;

- Filing claims; and
- Higher Cost Sharing amounts.

Benefit Year Maximum

Some Covered Services have a maximum number of days or visits that Anthem will allow during a Benefit Year. When the Deductible is applied to a Covered Service that has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if You have satisfied the applicable Out-of-Pocket Limit. See the "Schedule of Benefits" for those services which have a Benefit Limit.

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 Subscriber Agreement'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 Subscriber Agreement 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 Subscriber Agreement and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable Prior Authorization, Utilization Review or other requirements set forth in Your Subscriber Agreement.

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

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

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

Provider Network Status

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

An In-Network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Subscriber Agreement is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit 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.

Except for Surprise Billing Claims, We will calculate the Maximum Allowed Amount for Covered Services You receive from an Out-of-Network Provider, using one of the following:

1. An amount based on Our Out-of-Network Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering 1 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 1 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; or
6. An amount based on the Medicaid fee schedule established by the State. When basing the Maximum Allowed Amount upon the level or method of reimbursement established by the State for Medicaid, Anthem will update such information no less than annually.

Providers who are not contracted for this product, but are contracted for other products with Us are also considered Out-of-Network. For this Subscriber Agreement, the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between Us and that Provider specifies a different amount or if Your claim involves a Surprise Billing Claim.

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

Unlike In-Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider’s charge that exceeds Our Maximum Allowed Amount unless Your claim involves a Surprise Billing Claim. 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 Subscriber Agreement’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 PBM.

Member Cost Share

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

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, We may authorize the In-Network Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstances, You must contact Us in advance of obtaining the Covered Service. We also may authorize the In-Network Cost Share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize an In-Network Cost Share amount to apply to a Covered Service received from an Out-of-Network Provider, You may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless (i) You have received a "surprise bill" from an Out-of-Network Provider or (ii) You were required to utilize an Out–of-Network Provider due to network inadequacy pursuant to and in accordance with applicable law. Please contact Member Services for Authorized Services information or have Your Provider contact Us to request authorization.

Exception Request Due to Network Inadequacy

Network Inadequacy is when there isn't an In-Network Provider to provide care or treatment for Your specific illness or injury, or if there is unreasonable travel or delay to see an In-Network Provider. Please Note that Network Inadequacy does not include when You are temporarily living outside the Local Network Area (e.g., when You are a Student at School).

Usually there will be a Provider in Our Network to treat Your specific illness or injury. If You or Your Doctor can't find a Provider in Our Network or can't find a network Provider that does not involve unreasonable travel or delay, please call Member Services at the phone number on the back of Your Identification Card for help.

Member Services will first try to locate an In-Network Provider for You. If due to Network Inadequacy there is no suitable In-Network Provider then You or Your Provider may request an exception for an Authorized Service to see an Out-of-Network Provider. You or Your Doctor will be asked to provide information about Your treatment in order to approve the request for Authorized Services from an Out-of-

Network provider. We will provide a response to Your request within 15 days of receiving all required information necessary to issue a decision.

Approval to see an Out-of-Network Provider as an Authorized Services does not guarantee coverage under Your Plan. Services received by an Out-of-Network Provider must be covered under Your Plan, be Medically Necessary, and follow any Plan requirements, such as Precertification. Please see the "Requesting Approval for Benefits" section for more information.

Upon approval of an Authorized Service for Network Inadequacy, claims for Covered Services will be paid at the In-Network benefit level. This means You will be responsible for any applicable Cost Shares under Your plan, however You will not be responsible for the difference between the Maximum Allowable Amount (including any Cost Shares) and the amount billed by the Out of Network Provider.

If You elect to see an Out-of-Network Provider without obtaining authorization from Anthem, Your services will be covered at the Plan's Out-of-Network level. In addition, You may be responsible for paying the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge, plus any applicable Cost Shares.

Surprise Billing Claims (Surprise Bill)

Federal law protections against balance billing apply to care received in Emergency settings and in In-Network Facilities from Out-of-Network Providers. The law requires private health plans to cover surprise medical bills for Emergency services, including air ambulance services (but not ground ambulance services), as well as Out-of-Network Provider bills for services rendered at In-Network Hospitals and Facilities.

Patients are responsible for Cost Sharing no greater than what they pay for In-Network care, and their Cost Sharing applies to their In-Network Deductible and Out-of-Pocket Limit. Providers and Facilities are barred from sending patients a bill for amounts other than cost sharing that exceed the amount paid by the health plan or insurer.

Under Connecticut state law, a surprise bill is a bill for Covered Services (excluding Emergency care services), received by a Member for services rendered by an Out-of-Network Provider, where such services were:

1) rendered by an Out-of-Network Provider at an In-Network facility,
   a. during a service or procedure performed by an In-Network Provider, or
   b. during a service or procedure previously approved or authorized by Anthem, and
   c. the Member did not knowingly elect to obtain such services from such Out-of-Network Provider, or
2) upon the referral of an In-Network Provider to a clinical laboratory that is an Out-of-Network Provider.

In general, we must follow the protections under federal law, however, we will also apply the requirements under Connecticut law that go beyond the federal law protections to the extent they do not prevent or interfere with the application of federal law.

A surprise bill does not include a bill for Covered Services received by a Member when an In-Network Provider was available to render such services and the Member knowingly elected to obtain such services from another Provider who was Out-of-Network.

In certain situations, an Out-of-Network Provider must provide You with notice of their status as Out-of-Network. Should You agree in advance to accept services from an Out-of-Network Provider, You will be responsible for the Out-of-Network Cost Shares and any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges.

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 (“non-participating Providers”) don’t contract with the Host Blue. We explain below how We pay both kinds of Providers. Anthem covers only limited healthcare services received outside of the Anthem service area. For example, Emergency Care or Urgent Care services received at an Urgent Care Center obtained outside the Anthem service area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem.

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. Non-participating Providers Outside Our Service Area

1) Allowed Amounts and Member Liability Calculation

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

2) Exceptions

In certain situations, We may use other pricing methods, such as billed charges, 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 non-participating Providers. In these situations, You may be liable for the difference between the amount that the non-participating Provider bills and the payment We make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global® Core Program

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global® Core 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 Care, 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 Blue Cross Blue Shield Global® Core Service Center any time. They are available 24 hours a day, 7 days a week. The toll free number is 1-800-810-2583. Or You can call them collect at 1-804-673-1177.

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 Blue Cross Blue Shield Global® Core

In most cases, when You arrange Inpatient Hospital care with Blue Cross Blue Shield Global® Core, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

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

- Doctors services;
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global® Core; and
- Outpatient services.

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

When You need Blue Cross Blue Shield Global® Core claim forms You can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global® Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

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

Notice of Claim and Proof of Loss

After You get Covered Services, We must receive written notice of Your claim in order for benefits to be paid.

- In-Network Providers will submit claims for You. They are responsible for ensuring that claims have the information We need to determine benefits. If the claim does not include enough information, We will ask them for more details, and they will be required to supply those details within certain timeframes.
- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on Your behalf. However, if the Provider is not submitting on Your behalf, You will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claim form, You can send a written request to Us, or contact Member Services and ask for a claim form to be sent to You. We will send the form to You within 15 days. If You do not receive the claim form within 15 days, You can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
    - Name of patient.
    - Patient's relationship with the Subscriber.
    - Identification number.
    - Date, type, and place of service.
    - Your signature and the Provider's signature.

  Out-of-Network claims must be submitted within 90 days.

  The claim must have the information We need to determine benefits. If the claim does not include enough information, We will ask You for more details and inform You of the time by which We need to receive that information. Once We receive the required information, We will process the claim according to the terms of Your Plan.

  Please note that failure to submit the information We need by the time listed in Our request could result in the denial of Your claim, unless state or federal law requires an extension. Please contact Member Services if You have any questions or concerns about how to submit claims.

Claim Filing for Out-of-Network Emergency Services

If Emergency Services are provided by an Out-of-Network Provider, the Provider may bill Us directly for the services, and Your claim will be processed as required by law. The Out-of-Network Provider will be paid the greater of;

i. The amount the insured's healthcare Plan would pay for such services if rendered by an In-Network healthcare Provider;

ii. The usual, customary and reasonable rate for such services, or

iii. The amount Medicare would reimburse for such services.

The contact information for FAIR Health, Inc. is:

FAIR Health, Inc.
530 Fifth Avenue, 18th Floor
New York, NY 10036
PH: 1-855-301-3247
www.fairhealth.org

Payment of Covered Services

For claims filed in paper format, benefits for Covered Services provided to a Member will be processed and paid to the Provider within 60 days of the date the claim is received by Anthem. However, if Anthem requires additional information to process and pay the claim, Anthem will send written notice to the Member or the Provider of the need to send in additional information required to process the claim within 30 days after Anthem receives the claim. Anthem will pay the claim not later then 30 days after Anthem

receives the information requested to process and pay the claim under the contract. Before the end of the initial 60 day period, Anthem will send the Member written notice of the reason(s) for the delay.

For claims filed in electronic format, benefits for Covered Services provided to a Member will be processed and paid to the Provider within twenty 20 days of the date the claim is received by Anthem. However, if Anthem requires additional information to process and pay the claim, Anthem will send written notice to the Member or the Provider of the need to send in additional information required to process the claim within 10 days after Anthem receives the claim. Anthem will pay the claim not later then 10 days after Anthem receives the information requested to process and pay the claim under the contract. Before the end of the initial 20 day period, Anthem will send the Member written notice of the reason(s) for the delay.

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.

Claim Denials

If benefits are denied, in whole or in part, Anthem will send the Member a written notice within the established time periods described in the section “Payment of Benefits.” The Member or the Member’s duly authorized representative may Appeal the denial as described in the “If You Have a Complaint or an Appeal” section. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim Appeal procedures and time limits.

If the denial involves a Utilization Review determination, the notice will also specify:

- Whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge;
- That an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Member upon request and at no charge.

Right of Recovery and Adjustment

Whenever payment has been made in error, or in excess of the maximum amount of payment necessary to satisfy the provisions of this Plan, 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.

Member’s Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker’s Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

This authorization remains valid until expressly revoked by notifying Us, Our affiliates, agents or designees in writing of such revocation at any time (except to the extent any action has been taken based on this authorization and/or except as release of such information may be required or authorized by law). Refusal to consent to the release of such information to Us, Our affiliates, agents or designees will permit Us to deny claims for benefits.

Assigning Coverage

A Member may not assign this Benefit Program or any of the Member's rights, benefits or obligations under this Subscriber Agreement to any other person or entity except with the prior written consent of Anthem, which consent may be conditioned by or withheld by Anthem in its sole discretion. Any attempted assignment by a Member in violation of this provision shall not impose any obligation upon Anthem to honor or give effect to such assignment and shall constitute grounds for cancellation of this Benefit Program, effective as of the date to which Premiums have been paid.

Notwithstanding the terms of any provision regarding the payment of benefits payable for a Covered Service, a Member may assign the benefits to a dentist or oral surgeon, who performs such services, in accordance with the Connecticut Law concerning Assignment of Benefits to a Dentist or Oral Surgeon.

Explanation of Benefits

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

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

Payment Owed to You at Death

Upon the death of a Member, claims will be payable in Our discretion to either the Member's estate or a beneficiary designated to Us. If the Provider is an In-Network/Participating Provider, claims payments will be made to the Provider.

Claims Review for Fraud, Waste and Abuse

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from non-participating or Out-of-Network Providers could be balanced billed by the non-participating or 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.

We also may identify certain Pharmacies to review for potential fraud, waste, abuse or other inappropriate activity when claims data suggests there may be inappropriate billing practices. If a Pharmacy is selected, then We may use one or more clinical utilization management strategies in the adjudication of claims submitted by this Pharmacy, even if those strategies are not used for all Pharmacies delivering services to this Plan's Members.

Payment Innovation Programs

We pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) - may include financial incentives to help improve quality of care and promote the delivery of healthcare 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 In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to Us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to healthcare. The Program payments are not made as payment for specific Covered Health Care Services provided to You, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by Us or to Us under the Program(s), and You do not share in any payments made by In-Network Providers to Us under the Program(s).

IF YOU HAVE A COMPLAINT OR AN APPEAL

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

A written Grievance must state plainly the reason(s) why You disagree with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The Grievance should include any pertinent documents and medical records 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. Also, please include the following details with Your Grievance if You have them:

- The Member's name, address and phone number;
- The identification number as shown on Your Identification Card (including the three-letter prefix);
- The name of the Provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which You don't agree; and
- Any bills that You have received from the Provider.

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

To file a grievance, send Your request in writing or call Member Services at the phone number on Your ID Card.

For Medical and Prescription Drug or Pharmacy Issues:

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

For Mental Health and Substance Abuse Issues:

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

How Are Grievances Handled?

If Your grievance is based on Medical Necessity, the appropriate clinical peer will review it. A clinical peer is a Doctor or other healthcare professional who holds a non-restricted license in a State of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. For a Substance Use or Mental Health Disorder, the clinical peer will have additional qualifications. All relevant information given to Us by You or on Your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. If Your grievance involves a Substance Use or Mental Health Disorder, We will use the required criteria to review Your request.

If Your grievance is not based on Medical Necessity, We will send it for appropriate administrative review.

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

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

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

Urgent (Expedited) Grievances:

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

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

We will let You know Our decision within 48 hours of receiving a request, or 72 hours from receipt of request if any portion of the 48 hour period falls on a weekend for an urgent grievance. We will let You know Our decision by phone, fax, or any other available means.

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

Mental Health Disorder and Substance Use Disorder

An urgent grievance is also available for:

- Substance Use Disorder or co-occurring Mental Health Disorder; or
- Inpatient services, Partial Hospitalization, residential treatment, or intensive Outpatient services needed to keep a covered person from requiring an Inpatient setting in connection with a Mental Health Disorder.

We will let You know Our decision within 24 hours of receiving an urgent grievance, for:

- Substance Use Disorder or co-occurring Mental Health Disorder; or
- Inpatient services, Partial Hospitalization, residential treatment, or intensive Outpatient services needed to keep a covered person from requiring an Inpatient setting in connection with a Mental Health Disorder.

We will let You know Our decision by phone, fax, or any other available means.

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

External Review with the Connecticut Insurance Department

If We deny Your request for coverage for a healthcare service or treatment, You may have the right to have Our decision reviewed by healthcare professionals who have no association with Us. You may file for external review with the Office of the Insurance Commissioner if a coverage decision involves making judgment as to the Medical Necessity appropriateness, healthcare setting, level of care or effectiveness of the healthcare service or treatment requested. You may file for an external review at any time within 120 days of the date You get an adverse or final adverse decision that You don't agree with.

You may be able to bypass Our internal grievance process and file a request for an expedited external review with the Connecticut Insurance Department within 120-days of the date You get a decision from Us that You don't agree with if any of the following circumstances apply:

1) If the covered person has a medical condition for which the time period for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review; or

2) If the adverse determination involves a denial of coverage based on a determination that the recommended or requested healthcare service or treatment is Experimental or Investigational and the covered person's treating healthcare professional certifies in writing that such recommended or requested healthcare service or treatment would be significantly less effective if not promptly initiated; or

3) We the health carrier failed to strictly adhere to the requirements with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review, regardless of whether the health carrier asserts that it substantially complied with the requirements of this section, or that any error it committed was de minimis.

4) We the health carrier have waived Our internal grievance process.

You, or Your Provider acting on Your behalf with Your consent, may also simultaneously file a request for an internal grievance and an urgent external review with the Connecticut Insurance Department Consumer Affairs Unit. You can request an external review if You meet any of the above requirements otherwise You must wait until Denial of the Health Carriers first level of internal Appeal. Please contact the State of Connecticut Insurance Department for more information:

Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
1-860-297-3910
1-800-203-3447 (toll-free)

If You ask for an urgent external review with the Connecticut Insurance Department at the same time as an urgent grievance with Us, the Independent Review Organization (IRO) assigned to Your review by the Insurance Commissioner will decide if You must finish the urgent internal review with Us before moving forward with the urgent external review.

An External Review Guide and application are available on the Department's website, www.ct.gov/cid.

You may ask for and get copies of all documents including the actual benefit provision, guideline, protocol or other similar criterion on which a decision is based. We will send this information within 5 business days after receiving Your request. We will send this information within 1 calendar day after receiving Your request about a final adverse coverage decision for:

- An admission, availability of care, continued stay, or healthcare service for which You received Emergency Services but haven't been discharged from a Facility; or
- A denial of coverage based on a decision that the recommended or requested healthcare service or treatment is Experimental or Investigational and Your treating Provider certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated.

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

Legal Action

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 Years of Our final decision on the claim or other request for benefits. If We decide an Appeal is untimely, Our latest decision on the merits of the underlying claim or benefit

request is the final decision date. You must exhaust Our internal Appeals process before filing a lawsuit or other legal action of any kind against Us.

Other Helpful Resources

You may contact the Consumer Affairs Division of the Connecticut Insurance Department or the Connecticut Office of the Health Care Advocate at any time. You can contact either office when the grievance process with Us is finished to file a civil suit in a court of competent jurisdiction.

Consumer Affairs Division of the Connecticut Insurance Department

Address: P.O. Box 816, Hartford, CT 06142
Phone: 1-860-297-3900 (local), 1-800-203-3447 (toll-free)
Email: cid.ca@ct.gov

Connecticut Office of the Health Care Advocate

Address: P.O. Box 1543, Hartford, CT 06144
Phone: 1-866-466-4446 (toll-free)
Email: Healthcare.advocate@ct.gov

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 Subscriber Agreement 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 Subscriber Agreement, 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 Connecticut and meet the following applicable residency requirements:

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 applicable to this Subscriber Agreement.

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 applicable to this Subscriber Agreement.

6. Agree to pay for the cost of Premium that Anthem requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B, C 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. is seeking employment (whether or not currently employed); or
3. has entered with a job commitment.

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

For tax households with Members in multiple Exchange service areas:

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

Dependent Eligibility

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

1. The Subscriber's legal spouse.
2. The Subscriber's Domestic Partner - Domestic Partner or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way including by adoption or blood) that would prohibit him or her from being married under State law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a. For purposes of this Subscriber Agreement, 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.
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 impairment. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's impairment 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 Subscriber Agreement.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Subscriber Agreement 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), during the annual open enrollment period or as an enrollee to add a Qualified Individual to the current QHP during 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 1 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 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 to enroll in or change a QHP as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption; guardianship;
- 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 Subscriber Agreement 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;
- 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;
- A Qualified Individual or Dependent who is pregnant, but not more than 30 days after the commencement of the pregnancy, as certified by a licensed healthcare Provider acting within the scope of such healthcare Provider's practice; and
- A Qualified Individual newly gains access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

If You cannot find Your situation, contact Your agent/broker or call Us. We can only enroll based on events defined by State and/or federal law.

NOTE: Special enrollment for marriage – only applies if at least one spouse was enrolled in Minimum Essential Coverage at least one day in the 60 days before marriage; or lived abroad for one or more days in the 60 days before marriage; or is an American Indian or Alaskan Native.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 61 days from the date of birth. To ensure coverage continues beyond the first 61 days, please contact the Exchange within 61 days of the date of birth to confirm the child is added to the Subscriber's Agreement and You must pay Anthem timely for any additional Premium due.

A child will be considered adopted from the earlier of: (1) placement for adoption; or (2) the date the court enters a decree granting the adoption. 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 61 days of the placement for adoption or date of adoption to add the child to the Subscriber's Agreement and You must pay Anthem timely for any additional Premium due.

Adding a Child due to Award of Court-Appointed 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 Agreement 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 Subscriber Agreement, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Subscriber Agreement and once approved by the Exchange, We will provide the benefits of this Subscriber Agreement 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 Subscriber Agreement will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

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

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship 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 or appointment of guardianship 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;
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;
4. In the case of a Qualified Individual or Dependent who is a pregnant Individual as certified by a licensed healthcare Provider acting within the scope of such healthcare Provider's practice, coverage is Effective on the first of the month in which the Individual receives certification; and
5. In the case of new access to an ICHRA or new provision of a QSEHRA, if the Plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the Plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following the Plan selection.

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

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment;
6. Individual who no longer resides, lives or works in the Anthem's service area;
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
8. Termination of employer contributions; or
9. Exhaustion of COBRA benefits.

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

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

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under: this Subscriber Agreement. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, changes in income, change of Dependent's impairment 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 or enrolled in Medicare.

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

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete and understand that all rights to benefits under this Subscriber Agreement are subject to the condition that all such information is accurate. 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;
7. The Member was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange; or
8. The QHP Issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP Issuer as required by law.

"Grace Period" refers to either:

1. The three 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 three 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) 14 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 14 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. When a Member is no longer eligible for coverage in a QHP through the Exchange due to being an overage Dependent, the last day of coverage is the annual renewal date of this Subscriber Agreement on or after the date on which the Member turns age 26.

4. In the case of a termination for non-payment of Premium and the three 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 three 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.
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 Subscriber Agreement, shall become the Subscriber.

"Reasonable notice" is defined as 14 days prior to the requested Effective Date of termination.

Guaranteed Renewable

Coverage under this Subscriber Agreement 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 Subscriber Agreement 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 Subscriber Agreement.
3. This Subscriber Agreement 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 years after the Effective Date of this Subscriber Agreement, 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 Subscriber Agreement as of the original Effective Date. Additionally, if within two years after adding an additional Dependent (excluding newborn children of the Subscriber added within 61 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 Subscriber Agreement.

This Subscriber Agreement 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 Subscriber Agreement. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two 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.

Time Limit on Certain Defenses

This Subscriber Agreement shall be incontestable, except for nonpayment of Premium, after it has been in force for two Years from its date of issue.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:00 a.m. and ends at 11:59 p.m. Eastern Time.

Discontinuation of Coverage

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

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either the three 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 Subscriber Agreement is terminated. In order for a Premium to be considered paid during the grace period, we must receive it by the last day of the grace period. 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 Year We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the three month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to terminate the Subscriber Agreement 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 three month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Subscriber Agreement 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 Subscriber Agreement will stay in force unless prior to the date Premium payment is due You give timely written notice to Us that the Subscriber Agreement is to be terminated. If You do not make the full Premium payment during the grace period, the Subscriber Agreement will be terminated on the last day of the grace period. You will be liable to Us for the Premium payment due including 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 grace period.

After Termination

Once this Subscriber Agreement 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 Subscriber Agreement. 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. We shall not routinely issue a Premium refund in amounts of less than 1 dollar.

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

Premiums

The amount, time and manner of payment of Premiums shall be determined by Anthem and shall be subject to the approval of the State of Connecticut Insurance Department.

(1) All Premiums shall be due and payable in full and in advance for the period in which this Benefit Program provides benefits.

(2) Failure of the Subscriber to remit Premium due shall void the eligibility of the Subscriber and his or her Dependents to receive benefits covered under this Benefit Program. In such cases, the Subscriber will become financially responsible for any services rendered as of the last day covered by the last Premium received by Anthem.

(3) Anthem may apply refunds and credits for the following reasons:

a) The death of the Subscriber or his or her Dependent;

b) The Subscriber has prepaid beyond the cancellation date;

c) The Premium has been prepaid beyond the cancellation date; or

d) Overpayments.

(4) In no event will a refund or credit be made for more than a period of 12 months from the date of the qualifying event.

(5) Refunds and credits will not be pro-rated for less than 61 days.

(6) In the event that Anthem does not receive the required Premium for the initial 61 days following birth of a newborn as outlined above, Anthem may (i) refuse to allow the newborn to be added to this Subscriber Agreement following the 61 day period after the date of birth; or (ii) file a court action against the Subscriber and/or the spouse (if they are married) for the additional Premium if required for the first 61 days after birth.

Note: Anthem will not deny any claims for Covered Services rightfully incurred and/or paid for the newborn child during the first 61 days following birth, including claims for Covered Services received in its own right that exceed the mother's maternity benefit.

Changes in Premium

The Premium rates are guaranteed for the 12 month period following the first day of the Calendar Year.

The Premium for this Subscriber Agreement may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records at least 30 days prior to such change. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Payment of the Premium by the Subscriber shall serve as notice of the Subscriber's acceptance of the change.

How to Pay Your Premium

After making Your initial Premium payment, You can make future payments by the following methods:

- online at www.anthem.com
- by mail using the address on Your Premium notice

- by authorizing Us to automatically deduct Your Premium payment from Your financial institution account every month
- by using Our mobile application
- pay in person at any approved retailer found on the mobile application

To learn more about any of these options, please contact Member Services at the number on the back of Your Identification Card.

Electronic Funds Transfer

If You submit a personal check for Premiums payment, You automatically authorize Us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on the financial institution account statement as an Electronic Funds Transfer (EFT). Converting Your paper check into an electronic payment does not authorize Us to deduct Premiums from Your account on a monthly basis unless You have given Us prior authorization to do so.

Administrative Fee

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

Premiums Paid by a Third Party

Anthem will accept Premium payments made on behalf of Subscribers if the Premium is paid by the following persons or entities:

- The Ryan White HIV/AIDS Program;
- Other Federal and State government programs that provide Premium and Cost Sharing support for specific individuals;
- Indian tribes, tribal organizations and urban Indian organizations; or
- A relative or legal guardian on behalf of a Subscriber.

Unless required by law, Anthem does not accept Premium payments from third parties that are not listed above. Examples of third parties from whom Anthem will not accept Premium payments include, but are not limited to, Providers, Hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan.

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 the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

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

Confidentiality and Release of Information

Applicable State and federal law requires Us to undertake efforts to safeguard Your medical information.

For informational purposes only, please be advised that a statement describing Our policies and procedures regarding the protection, use and disclosure of Your medical information is available on Our website and can be furnished to You upon request by contacting Our Member Services department.

Obligations that arise under State and federal law and policies and procedures relating to privacy that are referenced but not included in this Subscriber Agreement are not part of the Subscriber Agreement between the parties and do not give rise to contractual obligations.

Release of Records

By Your enrollment application, You have agreed to allow all Providers to give Us needed information about the care they provide to You to the extent permitted by law.

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.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond Our control, We may be unable to process Your 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. In such an event, however, We shall use reasonable efforts to perform Our respective obligations.

Changes to the Subscriber Agreement

This Subscriber Agreement shall remain in effect unless amended, terminated, rescinded, suspended or cancelled as described herein. Anthem may amend the Subscriber Agreement with approval from the State of Connecticut Department of Insurance. The Effective Date of such changes shall be designated by Anthem, and notification to Subscribers will be provided by Anthem.

No agent or representative of Anthem, other than an officer of Anthem, is authorized to change this Benefit Program or to waive any of its provisions. Any such changes or waivers must be in writing.

Anthem has the right to develop medical and managed care policies and procedures and to amend such policies and procedures from time to time. The Effective Date of such changes shall be designated by Anthem.

Clerical Errors

Clerical errors made in connection with the Benefit Program, whether by Anthem, or the Member will not terminate coverage that would otherwise have been effective; or continue coverage that would otherwise have ceased or should not have been in effect.

Coordination with Automobile Insurance

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

1) To charge the insurer obligated under such law for the dollar value of those benefits to which a Member is entitled.
2) To charge the Member for such dollar value, to the extent that the Member has received payment from any and all sources, including but not limited to, first party payment.

3) To reduce any sum owing to the Member by the amount that the Member has received payment from any and all sources, including but not limited to, first party payment.
4) A Member who fails to secure no-fault insurance required by applicable law shall be deemed to be his or her own insurer and Anthem shall reduce his or her benefits for Covered Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.
5) If a Member is entitled to benefits under a no-fault or other automobile insurance policy, benefits for Covered Services will only be provided when a Member follows all of the guidelines stated in the "Requesting Approval for Benefits" section of the Subscriber Agreement. It is necessary to follow all the guidelines in the "Requesting Approval for Benefits" section in order for Anthem to continue to provide benefits for Covered Services when the no-fault or other automobile insurance policy benefits are exhausted.

Coordination with Medicare

Unless federal law requires the Subscriber Agreement to be the primary payor, the benefits under this Subscriber Agreement for Members entitled to Part A or enrolled in Part B, do not duplicate any benefit Members are entitled to under Medicare. Where Medicare is the responsible payor, all amounts for services that have been paid for by Us that should have been paid for by Medicare shall be reimbursed to Us by or on behalf of the Members.

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 / Grievance process.

Entire Subscriber Agreement

This Subscriber Agreement, including the endorsements and the attached papers, if any, make up the entire contract of coverage. We have discretionary authority to determine Your eligibility for benefits and to construe the provisions of the Subscriber Agreement. Please see the "Authority for Discretionary Decisions" provision in this section.

The Membership enrollment application and rate page are incorporated by reference herein.

A Member shall complete and submit to Anthem such applications or other forms or statements as Anthem may reasonably request. A Member warrants that all information contained therein shall be true, correct, and complete to the best of the Member's knowledge and belief and the Member accepts that all right to benefits under this Benefit Program are conditional upon said warranties. No statement by the Member in his or her enrollment application shall void this Subscriber Agreement or be used in any legal proceeding unless such enrollment application or an exact copy thereof is included in or attached to the Subscriber Agreement.

Misstatement of Age

If the Premium for this Subscriber Agreement is based on Your age and if Your age has been misstated, the benefits will be those the Premium paid would have purchased at the correct age.

Notice

Any notice given by Anthem to a Subscriber shall be sufficient if mailed to the Subscriber at his or her address as it appears in Anthem's records. Notice given to Anthem must be sent to Anthem's address as

shown in this Subscriber Agreement. Anthem, or a Member may, by written notice, indicate a new address for giving notice.

Anthem as the Insurance Carrier

Anthem does not furnish Covered Services. Anthem makes payment of the Maximum Allowed Amount for Covered Services received by Members. Anthem is not liable for any act or omission of any Doctor, Provider or Hospital. Anthem has no responsibility for a Doctor's, Provider's or Hospital's failure or refusal to render Covered Services to a Member.

Anthem's sole obligation is to provide the benefits described in the Subscriber Agreement. No action at law based upon or arising out of the Doctor-patient, Provider-patient or Hospital-patient relationship may be maintained against Anthem.

The use or non-use of an adjective such as "participating" or "non-participating" in modifying the term "Doctor," "Provider" or "Hospital" is not a statement as to the ability of the Doctor, Provider or Hospital.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably be required during the pendency of a claim and to make an autopsy in case of death where it is not prohibited by law.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need. Subject to applicable privacy restrictions, We may obtain needed facts from, or give them to, any other organization or person. We need not tell You or obtain Your consent to do this. Each person claiming benefits under this Plan must give Us any facts We need to pay the claim.

Plan Description Information

Participating Provider Reimbursement

Reimbursement methodologies include but are not limited to the following:

- Participating Providers are paid according to a fee-schedule for services rendered, which is an amount these Providers accept as compensation in full for Covered Services. Individual Providers can contract through a corporate entity in an assumed risk-sharing position with Anthem for services rendered by professional Providers whom the entity represents.
- Global Case Rate: This is an amount for pre-procedure, procedure and post-procedure covered benefits which are all related to the same Covered Service.
- Global Capitation: This involves setting healthcare budget for each Member of a healthcare delivery system. The delivery system tries to perform at or under the amount. If successful, the delivery system shares in the success. If it fails, the delivery system is accountable for amounts over budget on an annual basis.

Participating Institutional Providers

Institutional Providers include, but are not limited to: general Hospitals, rehabilitation Hospitals, ambulatory surgery centers, and behavioral health facilities.

Reimbursement methodologies include but are not limited to the following:

- Billed charges;
- Discounts off billed charges;
- Per day payments;
- Per episode-of-care payments; and
- Fixed payment per Member per month.

Member Satisfaction Information

PPO Satisfaction:

Overall, 70.29% of Anthem Members have positive rating regarding their health plan. To reach Anthem during normal business hours (8:00 a.m.-5:00 p.m.) please call the telephone number indicated on the back of Your Identification Card. After normal business hours: Members may call the same telephone number, and receive information via an automated telephone system. A Member may also receive information via Anthem Blue Cross Blue Shield website at www.Anthem.com. This website is available 24 hours every day, seven days a week.

Medical Loss Ratio

For insurance entities, the term “medical loss ratio“ refers to the ratio of incurred claims to earned Premium for a prior Calendar Year. The MLR is calculated for managed care (HMO) and PPO/Indemnity plans, 1 for State law purposes and the other as determined under federal law. For 2020 Anthem’s Medical Loss Ratio for State law purposes was 86.47% for HMO plans and 80.89% for PPO/Indemnity plans. For 2020 Anthem’s MLR for federal law purposes was 84.10% for Individual plans.

Utilization Review Determinations

During 2020 Anthem’s Utilization Review department determined the following, based on its review of each case relative to Medical Necessity and Covered Services parameters (for Connecticut enrollees only):

Requests for Utilization Review:	119,288
Number of Utilization Review denials:	11,066
Number of Appeals of denials:	389
Number of denials reversed or negotiated upon Appeal:	148

To reach Anthem’s Utilization Review department, call (in-State) 1-800-238-2227 or (out-of-State) 1-800-248-2227. The telephone system is capable of accepting and recording calls received after hours, on weekends, and holidays. Callers are provided with instructions and may leave a recorded message with detailed information. Calls are returned during normal business hours no later than one business day from the date on which the call was received or the details necessary to respond are received from the caller.

Member Notification

When a Primary Care Physician leaves the network, Anthem is responsible for informing the Member in writing within 30 days of the date of the Primary Care Physician’s departure.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding Anthem’s standards for the collection, use and disclosure of information gathered in connection with Anthem’s business activities.

- Anthem may collect personal information about a Member from persons or entities other than the Member.
- Anthem may disclose Member information to persons or entities outside of Anthem without Member authorization in certain circumstances.
- Member has a right of access and correction with respect to all personal information collected by Anthem.
- A more detailed notice will be furnished to You upon request.

Authority for Discretionary Decisions

Anthem, or anyone acting on its behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, Anthem, or anyone acting on its behalf, has complete discretion to determine the administration of the Member's benefits. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental-Investigative, whether surgery is cosmetic, and whether charges are consistent with its Maximum Allowed Amount. However, a Member may utilize all applicable Member Appeal procedures.

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

Severability

In the event that any provision in this Subscriber Agreement is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the Subscriber Agreement will remain in force and effect.

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.

Right to Change Plan

No agent or employee of the Plan or other person, except an authorized officer of the Plan, has authority to waive, even if by providing incomplete or incorrect information, any conditions or restrictions or to change the form or content of this Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information. Such changes can be made only through a written amendment, signed by an officer of the Plan.

Workers' Compensation

To the extent permissible by law, including without limitation section 38a-500 of C.G.S., no benefits shall be provided for Covered Services paid, payable or eligible for coverage under any Workers'

Compensation Law, employer's liability or occupational disease law, denied under a managed Workers' Compensation program as Out-of-Network services or which, by law, were rendered without expense to the Member.

To the extent permissible by law, including without limitation section 38a-500 of C.G.S. Anthem shall be entitled to the following:

1) To charge the entity obligated under such law for the dollar value of those benefits to which the Member is entitled.
2) To charge the Member for such dollar value, to the extent that the Member has been paid for the Covered Services.
3) To reduce any sum owing to the Member by the amount that the Member has received payment.

4) To place a lien on any sum owing to the Member for the amount Anthem has paid for Covered Services rendered to the Member, in the event that there is a disputed and/or controverted claim between the Member's employer and the designated Workers' Compensation insurer as to whether or not the Member is entitled to receive Workers' Compensation benefits payments.

5) To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.

6) If a Member is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines in the "Requesting Approval for Benefits" section in order for this Benefit Program to continue to provide benefits for Covered Services when the Workers' Compensation benefits are exhausted.

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 healthcare 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.

Medical Policy and Technology Assessment

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

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

Program Incentives

We may offer health related incentives from time to time, at Our discretion, in order to introduce You to covered programs and services available under this Subscriber Agreement. The purpose of these incentives includes, 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 health related items including but not limited to retail coupons, gift cards, 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.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under Your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Subscriber Agreement

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.

Wellness Program

1. **Purpose.** The purpose of this wellness program is to encourage You to take a more active role in managing Your health and well-being.
2. **Description.** We provide benefits in connection with the use of or participation in the following wellness and health promotion action:
   - Wellness Visit Incentive Program. Subscribers and the Subscriber's covered spouse or domestic partner who receive an annual wellness physical examination are eligible to receive a reward payout once the action is completed during the first 90 days of the Calendar Year or during the first 90 days of Your enrollment.
   - Health Assessment Incentive Program. A Health Assessment is an online health tool. You will answer questions about Your lifestyle, current health and history. You will have access to a personal report with health tips and available online programs. Subscribers and the Subscriber's covered spouse or domestic partner who complete the Health Assessment are eligible to receive a reward payout once the action is completed.
3. Eligibility. You, the Subscriber and the Subscriber's covered spouse or domestic partner can participate in the wellness program.
4. Participation. When We receive a claim from Your Provider for an annual wellness physical examination, You will receive a Health Rewards card in the mail or if You previously received a Health Rewards card, Your reward will be electronically loaded onto it.
5. Rewards. The rewards are in the form of a gift card which is redeemable at participating retailers for health related purchases (gift cards prohibit the purchase of alcohol, tobacco, and firearms).

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

CareMore Health Program

You may qualify to receive healthcare services offered by CareMore Medical Group of Connecticut (CareMore), an Anthem network Provider. CareMore is a team of healthcare professionals consisting of Physicians, nurse practitioners, medical assistants, case managers and social workers who provide care for qualified Anthem Members in their own home or at a CareMore Care Center.

CareMore is a voluntary program through which qualified Members can receive care coordination and comprehensive primary care services for a number of complex medical conditions, including diabetes, congestive heart failure, chronic obstructive pulmonary disease and chronic kidney disease. Members may apply for admission to the program and are eligible for enrollment if they meet specified requirements. Once enrolled in the program, the CareMore care team works with Members and their PCP to deliver comprehensive primary care that may help them achieve their best state of health.

Anthem Community Care Coordination

You may qualify for Anthem's Community Care Coordination program. The program uses social determinants of health (SDoH) to identify and close gaps in Members' health care. Social determinants of health (SDoH) are conditions in the places where people live, learn, work and play. These conditions affect a wide range of health and quality-of-life outcomes and risks. This program seeks to provide an extra layer of support to Members needing help navigating the complex health care system to improve health outcomes.

If You are determined to have a potential gap related to SDoH, a Care Coordinator will reach out to help identify and connect You with resources to help with any number of concerns. These range from understanding post discharge instructions, coordinating resources and interventions, connecting You to Your PCP or other In-Network Providers, home services, or identifying for you low/no cost community available services to help reach Your best health and quality of life status.

There is no cost for Care Coordinator services, however You may have cost shares for any Covered Services or prescription drugs You receive, and some community services may have a fee. These programs are not guaranteed and could be discontinued at any time. Your participation in the program is optional.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have rights and responsibilities when receiving healthcare. As Your healthcare partner, We want to make sure Your rights are respected while providing Your health benefits. That means giving You access to Our network of healthcare 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 healthcare Providers about all healthcare options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your Plan.
- Work with Your Doctors to make choices about Your healthcare.
- 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 healthcare 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 healthcare Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

Get help at any time, by calling the Member Services number located on the back of Your ID Card or by visiting Anthem.com.

Or contact Your local insurance department:

CONNECTICUT

Phone: 1-800-203-3447
Write: State of Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.

- Follow all health Plan rules and policies.
- Choose an In-network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all Doctors, healthcare Providers and staff with respect.
- Keep all scheduled appointments. Call Your healthcare 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 healthcare Providers to make a treatment plan that You all agree on.
- Inform Your healthcare 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 healthcare plan that You have agreed on with Your healthcare Providers.
- Give Us, Your Doctors and other healthcare Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with Us.
- Inform Member Services if You have any changes to Your name, address or family Members covered under Your Plan.

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

We want to provide high quality benefits and customer service to Our Members. Benefits and coverage for services given under the Plan are overseen by Your Subscriber Agreement, 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 contract so they are easy to identify.

Advance Payments Of The Premium Tax Credit (APTC)

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

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

Anthem Blue Cross and Blue Shield (Anthem)

The company providing the coverage under this Subscriber Agreement. The terms We, Us and Our in this Certificate refer to Anthem and its designated affiliates.

Appeal

A formal request by You or Your representative for reconsideration of a decision not resolved to Your satisfaction. See the “If You Have a Complaint or an Appeal” section of this Subscriber Agreement.

Authorized Service

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. For more information, see the “How Your Claims Are Paid” section.

Benefit Year

The period of time that We pay benefits for Covered Services. Generally, the Benefit Year is a Calendar Year for this Plan, as listed in the ”Schedule of Benefits.” If Your coverage ends earlier, the Benefit Year ends at the same time.

Benefit Program

The term Benefit Program means the program of healthcare benefits that is identified on the cover page of the Subscriber Agreement and described herein.

Biosimilars

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

Brand Drugs

Prescription Drugs that We classify as Brand Drugs or Our PBM has classified as Brand Drugs through use of an independent proprietary industry database.

Calendar Year

A period beginning on January 1 and ending on December 31 of the same Year.

Coinsurance

The percentage of the Maximum Allowed Amount that You pay for some Covered Services.

Controlled Substances

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

Copayment

A fixed amount You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service. The Copayment does not apply to the Deductible.

Cost Share (Cost Sharing)

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

Covered Services

Services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit and that is listed under the "What is Covered" section.
- Within the scope of the Provider's license;
- Rendered while coverage under this Subscriber Agreement is in force.;
- Not Experimental or Investigational or not covered by this Subscriber Agreement; and
- Authorized in advance by Us if such preauthorization is required in Subscriber Agreement.

Deductible

The amount of charges You must pay for any Covered Services before any benefits are available to You under this coverage. Your Deductible is stated in Your "Schedule of Benefits".

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 "Pediatric Dental Care" section for more information.

Dependent

A Member of the Subscriber's family who meets the rules listed in the "When Membership Changes (Eligibility)" section and who has enrolled in the Plan.

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.

Effective Date

The date when a Member's coverage begins under this Subscriber Agreement.

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:

1) A medical or behavioral health screening examination that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition, and
2) Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment to stabilize the patient.

The term "**stabilize**" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to 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.

Exchange

A governmental agency or non-profit entity that makes Qualified Health Plans such as this Plan available to Qualified Individuals.

Experimental or Investigational

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines in its sole discretion to be Experimental or Investigational.

1. Anthem 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; or
   - Has been determined by the FDA to be contraindicated for the specific use; or
   - Is provided as part of a clinical research protocol or Clinical Trial or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
   - Is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or
   - Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental 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.
2. Any service not deemed Experimental or Investigational based on the criteria in subsection A. may still be deemed to be Experimental or Investigational by Anthem. In determining whether a service is Experimental or Investigational, Anthem will consider the information described in subsection C. and assess the following:
   - Whether the scientific evidence is conclusory concerning the effects of the service or health outcomes;
   - Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
   - Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives;

- 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.

3. The information considered or evaluated by Anthem 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:
    - Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
    - Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
    - Documents issued by and/or filed with the FDA or other federal, State or local agency with the authority to approve, regulate, or investigate the use of the drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
    - Documents of an IRB or other similar body performing substantially the same function; or
    - Consent document(s) used by the treating Doctors, other medical professionals, or facilities or by other treating Doctors, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
    - The written protocol(s) used by the treating Doctors, other medical professionals, or facilities or by other treating Doctors, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
    - Medical records; or
    - The opinions of consulting Providers and other experts in the field.
4. Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply is Experimental or Investigational.
    - Notwithstanding the above, services or supplies will not be considered Experimental if they have successfully completed a Phase III Clinical Trial of the Federal Food and Drug Administration, for the illness or condition being treated, or the diagnosis for which it is being prescribed.
    - In addition, services and supplies for routine patient care costs in connection with a Clinical Trial will not be considered Experimental.

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, mental health Facility or a Mobile Field Hospital, as defined in this Subscriber Agreement. 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.

Freestanding Provider

A Provider (excluding Hospitals) that is not part of or owned by a Hospital and bill independently (i.e., not under a Hospital's name or ID number.) Certain Site-of-Service Providers meet these criteria and are considered "freestanding." Each participating Facility and provider type is subject to specific licensing, accreditation and credentialing requirements. These independent entities provide healthcare services such as laboratory tests, surgery, radiology and other services and are typically lower cost options for patients.

Generic/Generic Drugs

Prescription Drugs that We classify as Generic Drugs or that Our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active

ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Drug.

Habilitative Services

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

Home Delivery Pharmacy

A service where You get Prescription Drugs (other than Specialty Drugs) through a mail order service.

Home Health Care Agency

A Facility, licensed in the State in which it is located, which:

- Provides skilled nursing and other services on a visiting basis in the Member's home; and
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Doctor.

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.

Identification Card/ID Card

A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

In-Network

Covered Services are obtained from any Participating Physicians, Participating Hospital or Participating Provider.

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 Pharmacy Member Services at 1-800-700-2533.

Inpatient

A Member who receives care as a registered bed patient in a Hospital or other Facility where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than three hours per day, three days per week.

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.

Local Network Area

The term Local Network Area means the State of Connecticut and any area outside the State of Connecticut that Anthem designates as part of the Local Network Area for the Member.

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 Pharmacy Member Services at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowed Amount

The maximum amount that We will allow for Covered Services You receive. For more information, see the "How Your Claims Are Paid" Section.

Medicaid

Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medically Necessary (Medically Necessary Care, Medical Necessity)

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

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

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

For the purpose of this subsection "not more costly" means services is cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a Specialty Drug provided in the Outpatient department of a Hospital if the drug could be provided in a Doctor's office or the home setting.

Medicare

The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member

The Subscriber and enrolled Dependent.

Mental Health and Substance Abuse

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.

Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's healthcare 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.

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

Non-Participating Hospital

The term Non-Participating Hospital means any appropriately licensed Hospital which is not a Participating Hospital under the terms of this Benefit Program.

Non-Participating Physician

The term Non-Participating Physician means any appropriately licensed physician who is not a Participating Physician under the terms of this Benefit Program.

Non-Participating Provider

The term Non-Participating Provider means any appropriately licensed healthcare professional or Facility who is not a Participating Provider under the terms of this Benefit Program.

Out-of-Network

The term Out-of-Network means that Covered Services are obtained from any Non-Participating Physician, Non-Participating Hospital or Non-Participating Provider. Non-Participating Physician, Non-Participating Hospital or Non-Participating Provider also includes Providers who have not contracted or affiliated with Anthem's designated subcontractor(s) for the service they perform under this Subscriber Agreement.

Out-of-Network Pharmacy

A Pharmacy that does not have an In-Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You go to an Out-of-Network Pharmacy.

Out-of-Pocket Limit

The most You pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket Limit does not include Your Premium, amounts over the Maximum Allowed Amount, or charges for healthcare that Your Plan doesn't cover. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Subscriber Agreement. Please see the 'Schedule of Benefits" for details.

Outpatient

A Member who receives services or supplies when not an Inpatient.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than six hours per day, five days per week.

Participating Hospital

The term Participating Hospital means a Hospital designated and accepted as a Participating Hospital by Anthem to provide Covered Services to Members under the terms of this Benefit Program.

Participating Physician

The term Participating Physician means any appropriately licensed physician designated and accepted as a Participating Physician by Anthem to provide Covered Services to Members under the terms of this Benefit Program.

Participating Provider

The term Participating Provider means any appropriately licensed healthcare professional or Facility designated and accepted as a Participating Provider by Anthem to provide Covered Services to Members under the terms of this Benefit Program.

Pharmacy

A place licensed by State law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a prescription from Your Doctor.

Pharmacy and Therapeutics (P&T) Process

Process to make clinically based recommendations that will help You access quality, low cost medicines within Your Benefit Program. The process includes healthcare 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 Prescription Drug List. Our programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

Anthem's PBM, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Plan

The set of benefits, conditions, exclusions and limitations described in this document.

Precertification

Please see the section "Requesting Approval for Benefits" for details.

Premium

The monthly charge You must pay Anthem to establish and maintain coverage under this Agreement.

Prescription Drug

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 Drug List

Listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Doctors and pharmacists has been reviewed for their quality and cost effectiveness. This Prescription Drug List contains a limited number of Prescription Drugs, and may be different than the formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Drug coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. A description of the Prescription Drugs that are listed is available upon request and at www.anthem.com.

Prescription Order (Prescription)

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

Primary Care Physician ("PCP")

A Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Provider (Doctor): The term Provider means any appropriately licensed or certified healthcare professional or Facility providing healthcare services or supplies to Members.

> **Participating Provider**: The term Participating Provider means any appropriately licensed or certified healthcare professional or Facility designated and accepted as a Participating Provider by Anthem to provide Covered Services to Members.
>
> **Non-Participating Provider**: The term Non-Participating Provider means any appropriately licensed or certified healthcare professional or Facility which is not a Participating Provider.

Qualified Health Plan Or QHP

The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified health Plan Issuer or QHP Issuer

The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Rehabilitative Services

Healthcare 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 operating 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 that takes place in a structured Facility-based setting, and does not take place outdoors, e.g., wilderness program or therapy.
4) The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5) A Facility that is designated residential, subacute or intermediate care and may occur in care systems that provide multiple levels of care.
6) A Facility that is fully accredited by the Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO) or the Council on Accreditation (COA).

The term Residential Treatment 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
7) Wilderness therapy or programs

Retail Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Drugs) through a licensed pharmacist or Home Delivery Pharmacy service upon an authorized healthcare professional's order.

Self-Administered Drugs

The term Self-Administered drugs means drugs that are administered which do not require a medical professional to administer.

Site-of-Service Provider

Site-of-Service (SOS) providers are labs, radiology and imaging centers that meet cost and other criteria established by Anthem from time to time. They are:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e., not under a hospital's name or ID number.) Providers such as Radiology Providers, Reference Laboratories, and Ambulatory Surgery Centers meet these criteria and are considered "freestanding" Site-of-Service providers.
- An Outpatient Facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered "Site-of-Service" ("SOS").

These entities provide healthcare services such as laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating Facility is subject to specific licensing, accreditation and credentialing requirements.

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;
1) Care supervised by a Doctor;
2) 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; or a place for rest, educational, or similar services.

Specialty Care Physician (Specialist or SCP)

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

Specialty Drugs

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 or Home Delivery Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

State

The term State means each of the 50 States and the District of Columbia.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Billing Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Services received upon the Referral of an In-Network Provider to a clinical laboratory that is an Out-of-Network Provider;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network air ambulance services.

Subscriber

The Member who applied for coverage and in whose name this Subscriber Agreement is issued.

Subscriber Agreement

The agreement, between Us and the Subscriber, which is a summary of the terms of Your benefits. It includes this Subscriber Agreement, Your "Schedule of Benefits", Your application, any supplemental application or change form, Your Identification Card, and any endorsements or riders.

Substance Abuse Treatment Facility

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

Tax Dependent

The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer

The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

1. To file an income tax return for the Benefit Year
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
3. That no other taxpayer will be able to claim him, her or them as a Tax Dependent for the Benefit Year; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Urgent Care

Medical care for an unexpected illness or injury 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 Care Center

A licensed healthcare Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for Urgent Care.

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 and Our

Anthem Blue Cross and Blue Shield.

Year and Yearly

A 12 month period.

You and Your

The Member, Subscriber and each covered Dependent.

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 customer service telephone number on the back of your ID card.

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)

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)

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)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (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)

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)

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)

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)

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)

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)

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)

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)

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)

Navajo
Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíílnih. (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.