Anthem BlueCross BlueShield

MEA Benefits Trust

MEA Group
Companion Plan

Certificate of Coverage

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

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

048979 R7/2013

Introduction

This Certificate contains information that you need to know about your MEA Group Companion Plan coverage from Anthem Blue Cross and Blue Shield (Anthem BCBS). You are urged to read this Certificate of Coverage carefully.

This Certificate of Coverage explains how your MEA Group Companion Plan coverage works. It explains the terms, benefits, conditions, exclusions, and limitations of your coverage. It also includes information about eligibility requirements, enrollment for benefits, claim procedures and termination provisions.

The Basic Services coverage under this Plan supplements benefits paid under the Medicare program. The Additional Services coverage under this Plan provides benefits for some services not covered by the Medicare program and includes cost sharing in the form of deductibles, copayments and coinsurance.

The benefits described in this Certificate of Coverage are interpreted and administered according to the provisions and limitations herein. If there are coverage questions, Anthem Blue Cross and Blue Shield will base all decisions on the provisions in this Certificate of Coverage.

The Certificate of Coverage, any amendments or attached papers, the Schedule of Benefits, the group application, the Group Agreement, and your individual application make up your group contract and your complete coverage with Anthem Blue Cross and Blue Shield for health care benefits. This Certificate of Coverage replaces any previous Certificates of Coverage you may have received.

Paying Premium Charges and Renewal

Coverage is provided as stated in the Group Agreement. The coverage will renew automatically from year to year on the Anniversary/Renewal Date for additional one-year terms unless the Group or Anthem Blue Cross and Blue Shield gives written notice of termination, subject to the provisions in the Group Agreement. Payment for premium charges is due the first day of each month. If payment is received within 31 days of the due date - - the grace period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect premiums for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.

How to Obtain Language Assistance

Anthem is committed to communicating with our members about their health plan, regardless of their language. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service.

Kathleen S. Kiefer
Corporate Secretary
Anthem Blue Cross and Blue Shield

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Anthem Blue Cross and Blue Shield at the number listed on the back of your ID card.

048979 R7/2013

Table of Contents

Section One
Eligibility, Termination and Continuation of Coverage

Eligibility

Beginning Coverage
Before your coverage begins we must accept the group's application, your application, and payment for your coverage. The contract holder is responsible for sending us all applications, as well as notifying the subscriber of any changes in deductions for coverage, rate changes, changes in this contract or in any documents that comprise the contract, or termination of the contract or your coverage under the contract. The subscriber is responsible for making payments for coverage.

Paying Premium Charges
Payment for premium charges is due the first day of each month of coverage. To keep this coverage in effect, you or your contract holder must pay the premium charges when due, or your coverage will end with that due date. Coverage will be reinstated automatically if we receive the correct payment within 31 days of the due date - the grace period. We will decide whether to allow reinstatement once the grace period has ended.

How Do I Enroll in This Plan?
When you become eligible for this Plan, you are required to complete an enrollment form to enroll yourself, spouse, and disabled dependent, if applicable. Participation in this Plan is voluntary. Should you elect not to participate when you first become eligible, you must sign a waiver declining medical benefits.

NOTE: Only Medicare eligible members can be covered under this Plan. *If you are a non-Medicare-enrolled retiree, you may be eligible for the non-Medicare enrolled Health Plan.* If you have questions about the eligibility requirements for Group Companion Plan, please call the Customer Service number on the back of your ID card.

Who is an Eligible Group Member?
To be eligible for Group Companion Plan coverage, you must maintain both Medicare Part A and Part B. Family members with Medicare primary coverage who are eligible for Group Companion Plan include:

1. The subscriber;
2. The subscriber's legal spouse or domestic partner;
3. Disabled child/children enrolled in Medicare Part A and Part B;
4. The subscriber's legal spouse/domestic partner if they were covered as dependents at the time of the subscriber's death.

If your spouse, domestic partner, and/or children are eligible for group health coverage but are not enrolled in Medicare Part A and Part B or do not have primary benefits through Medicare, they cannot be covered under Group Companion Plan. *If they are otherwise eligible, they may be covered under the MEA's non-Medicare enrolled Health Plan.* These members include:

1. The subscriber's legal spouse or domestic partner.
2. The subscriber's/spouse's/domestic partner's children:
    - Under age 26

- Dependent children aged 26 years of age or older when the dependent is mentally or physically disabled. The disability must have begun before the child's 26th birthday, and the child must have been covered by us on and continuously since his or her 26th birthday.

Please note: Spouses of married dependent children are not eligible for coverage.

4. The subscriber's grandchild under age 26, living with the subscriber in a parent-child relationship and primarily supported by the subscriber. The subscriber may not enroll a child and grandchild at the same time under the same identification/policy number. The eligible child or grandchild may be covered under a separate identification/policy number.
5. The subscriber's legal spouse/domestic partner and children if they were covered as dependents at the time of the subscriber's death.

We will determine the effective date of coverage for the subscriber and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call us.

We reserve the right to verify continued eligibility for all members.

Effective Date of Coverage for Newly Eligible Subscribers and Their Dependents

Your coverage is effective on the first day of the month in which you reach age 65 and become eligible, as long as Blue Cross receives your enrollment application within 60 days of the date you became eligible. If you are already age 65 before you become eligible, your coverage is effective on the date you become an eligible retiree. Benefits for eligible dependents you enroll at the same time are effective on the same day subscriber benefits are effective. You must enroll when you are first eligible as described in this section.

Your Share of the Cost of the Plan

To be covered under this Plan, you must make any required contributions toward the cost of the coverage. The group is not responsible for any part of the premium payment for ongoing coverage for the spouse/domestic partner and unmarried children of the subscriber who were covered at the time of the subscriber's death.

Qualified Medical Child Support Order

If a qualified medical child support order is issued for your child, that child will be eligible for medical coverage as stated in the order. A qualified medical child support order is a judgment, decree, or order issued by a court of law which:

- Specifies your name and last known address;
- Specifies the child's name and last known address;
- Provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- States the period of time to which it applies; and
- Specifies each plan to which it applies.

A Qualified Medical Child Support Order may not require health care coverage that is not already included under the Plan.

Membership Additions

If you wish to add eligible family members after we have accepted your application, you must:

- Notify the contract holder;
- File an application; and
- Pay the applicable premium charge.

In most cases, the effective date of coverage for added family members will not be the same as your effective date of coverage. The contract holder can tell you when enrollment for added family members is allowed under this group contract.

Note: After retiring, membership additions are only allowed for the reasons listed below. If the added member has Medicare primary coverage, he or she is eligible for MEA Group Companion Plan. If the added member does not have Medicare primary coverage, he or she is eligible for an MEA non-Medicare enrolled Health Plan.

Family members who are eligible may be added because of marriage, formation of domestic partnership, birth, adoption or court order after the subscriber's effective date of coverage as follows:

Marriage When the subscriber marries, if we receive the spouse's (and children's, if applicable) completed application for change **within 60 days from the date of marriage**, coverage begins the first of the month that occurs immediately on or after the date we receive the application.

Domestic Partners If we receive a signed Affidavit of Domestic Partnership **within 60 days of the Affidavit having been signed**, coverage will begin on the first day of the month that occurs immediately on or after the date we receive the application.

Birth A newborn is automatically covered for 31 days from the moment of its birth unless the subscriber notifies us that the child will not be covered under the contract. For coverage beyond 31 days, if we receive a completed application for change w**ithin 60 days from the date of birth**, coverage is continuous from the moment of birth. We will collect applicable charges.

Adoption If we receive an adopted child's application for change **within 60 days from the date the child is adopted or placed for adoption with the subscriber and/or spouse**, coverage will begin on the date of placement. We will collect applicable charges. If a child placed for adoption is not adopted, all health care coverage will cease when placement ends. No continuation provisions will apply.

Court Order Changing Custody When a court order is issued changing custody of a dependent child, if we receive the application for change **within 60 days of the date of the court order**, coverage will begin on the date of the court order.

Return From Military Service If you return from full-time active service following a call to active military duty, no waiting period applies. You and eligible family Members can reenroll in the Plan, provided you apply for reemployment within the timeframe permitted under the Uniformed Services Employment and Reemployment Rights Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 31 days of your reemployment date. Coverage is effective on the effective date of your reemployment.

Termination of Coverage

The subscriber, the contract holder, or we can cause your coverage to end. If your coverage ends for any reason except misrepresentation, fraud or nonpayment, it will end on the first day following the grace period (see "Paying Premium Charges" earlier in this section for additional information). If termination of coverage is requested before the completion of the period for which we have accepted payment, payment may not be refunded, and coverage may continue until the end of that period. We reserve the right to take necessary action to collect premiums for the grace period.

Cancellation of the Group Contract

Notice of Cancellation If Group coverage is canceled as a result of the responsible individual's cognitive impairment or functional incapacity, the Group or subgroup may be eligible for reinstatement. The responsible individual is the person who is responsible for making premium payments on behalf of a Group or subgroup.

The right to reinstate Group coverage has the same limitations and requirements as listed in the "Notice of Cancellation" and "Right to Reinstatement" provisions as described in the "Cancellation of the Member's Contract" subsection.

This does not limit our right to cancel Group or subgroup coverage on the grounds that the employer is no longer in business, even if the end of the business results from the employer's cognitive impairment or functional incapacity.

By Notice Your group may cancel this contract by giving us prior written notice. It is the responsibility of your group to notify the subscriber of change in insurance carriers. All rights to benefits under this contract end on the date of cancellation.

For Non-Payment If the group fails to pay the premium charge, we may cancel the contract. If the group contract is canceled for non-payment, we will notify the subscriber of the cancellation prior to the termination date of the contract. We will not notify the subscriber of cancellation if the group provides notice to us that coverage has been replaced. Your coverage will continue in force for a grace period of 31 days from the date group payment is due for the premium charge.

Non-Renewal Your group may cancel the contract by not renewing the group contract with us. We may cancel the contract by not renewing the group contract if membership in your group falls below the minimum number of subscribers we require.

Other Cancellation Events We may cancel the group's contract if the group gives us fraudulent information or if the group does not meet our participation or contribution requirements.

Cancellation of the Member's Contract

Ending Employment or Eligibility If the subscriber ends employment or membership, or if you cease to meet the definition of eligible, as described in this section, your coverage will be canceled. We reserve the right to verify your initial and continued eligibility.

Deletion from Membership If you have been deleted from membership, your coverage will be canceled. The subscriber must delete a member from coverage if the member is no longer eligible for reasons such as the subscriber's divorce or legal separation, or a member's death. The subscriber must notify us of these events and complete a form to remove a member. If you do not promptly disenroll your dependents when they are no longer eligible, you will be fully responsible for all claims they incurred and for which benefits have been paid after they were no longer eligible.

Covered Children Your coverage will be canceled if you are a covered child and you cease to meet the definition of an eligible dependent.
Coverage Under An Alternate Plan If you are no longer eligible for Medicare primary benefits and enroll under another MEA Health Plan, your coverage under the Group Companion Plan will end when the alternate non-Medicare enrolled coverage begins.

Non-Payment of Charges Your contract will be canceled for your non-payment of premium charges.

Misrepresentation or Fraud If you make any intentional misrepresentation or use fraudulent means in applying for coverage or filing for benefits, your contract will be canceled. In such cases the contract will be null and void. If you make any intentional misrepresentation, intentional omission, or use fraudulent means to continue coverage when you no longer meet the eligibility requirements, your contract will be canceled as of the last date of eligibility. Any claims incurred after the date of eligibility for which we are unable to recover payment from the provider will be the responsibility of the subscriber.

Notice of Cancellation If your coverage is canceled for non-payment of premium charges or other lapse or default, we will send you a notice of cancellation. We will offer you the opportunity to reinstate your coverage. The charges will be the same amount they would have been if the contract had remained in force.

You have the right to designate another person to receive notice of cancellation of this contract for non-payment of charges or other lapse or default. We will send the notice to you and the person you designate at the last addresses you provided to us. You also have the right to change the person you designate if you wish. In order to designate a person to receive this notice or to change a designation, you must fill out a Third Party Notice Request Form. You can obtain this form from your group or by contacting us.

Right to Reinstatement Within 90 days after cancellation due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under a health insurance policy or certificate may request reinstatement on the basis that the loss of coverage was a result of the policyholder's cognitive impairment or functional incapacity

If you request reinstatement, we may require a Physician examination at your own expense or request medical records that confirm you suffered from cognitive impairment or functional incapacity at the time of cancellation. If we accept the proof, we will reinstate your coverage without a break in coverage. We will reinstate the same coverage you had before cancellation or the coverage you would have been entitled to if the Contract had not been canceled, subject to the same terms, conditions, exclusions, and limitations. Before we can reinstate your Contract, you must pay the amount due from the date of cancellation through the month in which we bill you. The charges will be the same amount they would have been if the Contract had remained in force.

If we deny your request for reinstatement, we will send you a Notice of Denial. You have the right to an Appeal, or to request a hearing before the Superintendent of Insurance within 30 days after the date you receive the Notice of Denial from us.

Certificate of Creditable Coverage When your medical coverage ends, Anthem BCBS will give you a written record of the coverage you received under the contract. You will receive a certificate of creditable coverage when your group coverage ends and upon your request (if the request is made within 24 months following termination of coverage). If you obtain future employment, you may need to submit the certificate of creditable coverage to that employer and it may reduce the duration of your subsequent employer's pre-existing condition limit, if there is one, by one day for each day of prior coverage (subject to certain requirements). If you are purchasing individual (non-group) coverage you may need to present the certificate of creditable coverage at that time as well.

Continuation of Coverage

If your group health coverage ends, you may be eligible for group continuation coverage (COBRA).

Group Continuation Coverage

Federal law requires that some employers sponsoring group health plans offer employees and their families a temporary extension of health coverage at the rate of your group premium charge plus an administrative

fee, when that coverage would otherwise end because of the occurrence of certain qualifying events. You are responsible for payment of the premium charge at your group rate plus the administration fee.

Qualifying events include:

- Death of the employee;
- Divorce or legal separation from the employee;
- A dependent child ceasing to be a dependent; and
- A covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act.

Notification - Under the law the employee or a family member (a qualified beneficiary) has the responsibility to inform us within 60 days of a:

- Divorce;
- Legal separation; and/or
- Child losing dependent status under the group health plan.

If you do not promptly disenroll your dependents when they are no longer eligible, you will be fully responsible for all claims they incurred and for which benefits have been paid after they were no longer eligible.

In any event, your continued group coverage under this contract (COBRA), will end if any of the following events occur:

- Your employer no longer provides our health insurance to any of its employees;
- We do not receive your premium charge payment. In such case, your COBRA coverage will be retroactively terminated to the first day of the period for which the premium charges have not been timely paid;
- You become a covered employee under any other group health plan after the date you elect COBRA continuation coverage;
- You remarry and become covered under a group health plan after the date you elect COBRA continuation coverage;
- You become entitled to benefits under Medicare after the date you elect COBRA continuation coverage; or
- Your COBRA entitlement period ends.

Continuation of Coverage Due To Military Service

In the event you are no longer actively at work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Military service means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate and upon payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

- The 18-month period (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) may be reinstated under this Certificate.

Section Two
Anthem ConditionCare Incentive Program

Anthem ConditionCare Incentive Program encourages Members to take action to manage their health by engaging in our ConditionCare Program. The ConditionCare Program is a disease management program that assists Members in the management of certain diseases by providing professional advice and support. Our nurse care managers will work with Members enrolled in the ConditionCare Program and promote the appropriate use of preventive care, screenings and medications associated with treating their disease. Member cost shares may be waived for certain services when Members work with their nurse care manager and engage in a ConditionCare Program. Benefits received at a reduced cost share level are referred to as Anthem ConditionCare Incentive Program. Prescription Medication and Medical Services and Supplies must be provided by Network professionals and providers, and if applicable to your plan, a referral from your primary care physician is necessary. Please refer to your Schedule of Benefits for any benefit limits that may apply.

Members engaged in the ConditionCare Program have access to the Anthem ConditionCare Incentive Program. Engaged in a ConditionCare Program means you have been contacted by one of our nurse care managers (or you have contacted one of our nurse care managers), have completed the appropriate assessment form, and have agreed to work with a nurse care manager to develop goals and work toward goal achievement if deemed necessary by the nurse.

Your Plan includes the following Anthem ConditionCare Incentive Programs:

Access to an Anthem ConditionCare Incentive Program means member's cost shares may be waived or reduced for prescription medication and medical services and supplies related to the management of the following disease(s):

Asthma

- FDA approved, prescription strength, self administered medications used for the treatment of asthma
- Certain counseling and educational services
- Hand held nebulizers, peak flow meter, and other durable medical equipment
- Allergy testing and allergy treatment of asthma triggers
- Select immunizations/vaccines

Chronic Obstructive Pulmonary Disease

- FDA approved, prescription strength, self administered medications used for the treatment of chronic obstructive pulmonary disease
- Pulmonary Function Studies/Barometry
- Pulmonary Rehabilitation
- Certain counseling and educational services
- Select immunizations/vaccines
- Office visits with spirometry PFT

Coronary Artery Disease

- FDA approved, prescription strength, self administered medications used for the treatment of Coronary Artery disease
- Select lab tests and screenings, including LDL-C, EKGs, stress testing, Chemistry Panel and HTN screening
- Cardiac Rehabilitation

- Certain counseling and educational services
- Select immunizations/vaccines

Diabetes

- FDA approved, prescription strength, self administered medications used for the treatment of diabetes (including insulins)
- Office Visits associated with treating diabetes, including retinal and foot exams
- Lab tests, including, but not limited to, HbA1c, LDL-C and microalibumin tests
- Certain counseling and educational services
- Select immunizations/vaccines
- Preferred Glucose meters and other durable medical equipment

Heart Failure

- FDA approved, prescription strength, self administered medications used for the treatment of congestive heart failure
- Select immunizations/vaccines
- Select Durable Medical Equipment
- EKGs and Lab tests, including, electrolytes, lipids, CBC tests
- Cardiac Rehabilitation and physical or occupational therapy
- Certain counseling and educational services

Member cost shares may be reduced as outlined on your Schedule of Benefits for certain prescription drugs that are self administered and are approved for the condition by the FDA (Food and Drug Administration), related to the ConditionCare Program applicable to your plan. In addition, the member cost shares may also be reduced for select medical devices used during the treatment of conditions listed above (i.e., peak flow meters, nebulizers, blood glucose test strips within allowed quantity limits). Members may obtain a list of drugs associated with this program by contacting Member Services or online at www.anthem.com.

Note:

- All applicable safety edits (quantity supply, days supply, gender, dose optimization, age), Prior Authorization and standard exclusions apply.
- Compounded products, most multi-source brands and metabolic products are not covered at the value tier.
- Anthem has the right to determine which drugs are appropriate to have copays reduced as it relates to the member's condition
- Copay reductions or waivers are not retroactive.
- Failure to comply with ConditionCare Program requirements may disqualify members from having their copays reduced.
- Copay reductions or waivers do not apply to medications administered in an inpatient facility, infusion suite, long term care facility, clinic, or administered by a home health vendor.

<u>Specialty Drugs</u>

Members who use certain covered specialty drugs may be required to purchase them through PrecisionRx Specialty Solutions, *Anthem's* specialty pharmacy network. *Members* may obtain a list of specialty drugs available through the specialty pharmacy by contacting Member Services or online at www.anthem.com. These specialty drugs will be covered only when obtained through this network.

<u>Mail Service Pharmacy</u>

Members may be required to fill their prescription medication through our mail service pharmacy if the medications are considered maintenance drugs. Members should refer to their Schedule of Benefits for rules specific to using mail service pharmacy.

Section Three
Covered Services - Basic Services

This section, along with Section 3 and Section 4, explains the types of health care services that are covered and not covered under the MEA's Group Companion Plan coverage.

This section describes the Group Companion Plan Basic Services benefits that are provided for Medicare Part A (hospital) and Medicare Part B (medical) deductible and coinsurance amounts. See Section 5 for a full explanation of Medicare deductible and coinsurance.

All benefits and covered services are subject to the deductibles, coinsurance, copayments, maximums, exclusions, limitations, terms, provisions and conditions of this contract, including any attachments and amendments or riders. Benefits for covered services are based on the maximum allowable amount.

Medicare Part A Deductible If you need hospitalization and your stay is 60 days or less in any Medicare benefit period, we provide benefits for the Medicare Part A deductible.

Medicare Part A Coinsurance If you need hospitalization and your stay exceeds 60 days in any Medicare benefit period, in addition to the Medicare Part A deductible, we provide benefits for the Medicare Part A daily coinsurance for:

- The 61st day through the 90th day; and
- After the 90th day, your 60 Medicare lifetime reserve days.

If your length of stay exceeds Medicare's limits, we will pay all of your Medicare Part A eligible expenses up to an additional 365 Group Companion Plan lifetime reserve days. Lifetime reserve days are extra days you can use only once. Once you use a lifetime reserve day, you cannot renew it.

Medicare Skilled Nursing Facility Coinsurance If you need after-hospital care in a skilled nursing facility and your stay is 100 days or less in any Medicare benefit period, we provide benefits for the Medicare Part A daily coinsurance. Care provided in a skilled nursing facility after the 100th day in any Medicare benefit period is not covered.

Medicare Part B Deductible We provide benefits for the Medicare Part B deductible.

Medicare Part B Coinsurance We provide benefits for the Medicare Part B coinsurance.

Medicare Part B Excess Charges If you receive Medicare Part B services from a doctor or supplier who does not accept Medicare assignment, we provide benefits for the difference between the Medicare-approved Part B charge and the maximum amount Medicare legally allows the doctor to charge. Benefits are not provided for amounts that exceed any charge limitation established by the Medicare program or state law. In this situation, you are not responsible for any charges in excess of this charge limitation.

Blood We provide benefits for the Medicare Part A or B blood deductible.

Section Four
Covered Services – Additional Services

This section, along with Section 2 and Section 4, explains the types of health care services that are covered and not covered under the MEA's Group Companion Plan coverage.

All benefits and covered services are subject to the deductibles, coinsurance, copayments, maximums, exclusions, limitations, terms, provisions and conditions of this contract, including any attachments and amendments or riders. Benefits for covered services are based on the maximum allowable amount.

Only medically necessary care is covered. Although Anthem BCBS does not provide benefits for covered services that do not meet our definition of medical necessity, you and your health care provider must decide what care is appropriate. The fact that a physician may prescribe, order, recommend or approve a service, treatment or supply does not make it medically necessary or a covered service and does not guarantee payment. If you choose to receive care that does not meet the Plan's definition of medical necessity, benefits will not be provided. You have the right to appeal this determination as outlined in Section 5. Anthem BCBS bases its decisions about medical necessity, experimental services and new technology on medical policy developed by Anthem BCBS. Anthem BCBS may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Some of the services described in this section are covered by Medicare only under certain conditions or according to a schedule that is less frequent than your Group Companion Plan coverage. When Medicare provides benefits for a service, Group Companion Plan will provide Basic Services benefits as described in Section 2. Only when Medicare does not provide benefits for a service described in this section will Group Companion Plan provide Additional Services benefits.

Acupuncture We provide benefits for acupuncture services.

Breast Reduction Surgery
The Plan provides benefits for medically necessary breast reduction surgery.

Clinical Trials We provide benefits for routine patient costs for items and services furnished in connection with participation in approved clinical trials. A member is eligible for coverage in an approved clinical trial if the following conditions are met:

- The member has a life-threatening illness for which no standard treatment is effective;
- The member is eligible to participate according to the clinical trial protocol with respect to treatment of such illness;
- The member's participation in the trial offers meaningful potential for significant clinical benefit; and
- The member's referring physician has concluded that the member's participation in the trial would be appropriate based on the above named criteria.

Routine costs do not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial or for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.

An approved clinical trial means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

Contraceptives We provide benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an outpatient basis.

Dental Procedures We will provide benefits for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the member is classified as vulnerable. Examples of vulnerable members include, but are not limited to the following:

- Infants
- Individuals exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to product a superior result
- Individuals with acute infection
- Individuals with allergies
- Individuals who have sustained extensive oral-facial or dental trauma
- Individuals who are extremely uncooperative, fearful or anxious

Diabetic Services We provide benefits for diabetes medication and supplies which are medically appropriate and necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program that is approved by us.

Durable Medical Equipment and Prostheses If more than one treatment, prosthetic device, or piece of durable medical equipment may be provided for your disease or injury, benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs. These terms apply to the following services:

Durable Medical Equipment We provide benefits for the rental or purchase of durable medical equipment. Whether you rent or buy the equipment, we provide benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, we will make monthly payments only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first.

Benefits for replacement or repair of purchased durable medical equipment are subject to our approval. We do not provide benefits for the repair or replacement of rented equipment.

Supplies are covered if they are necessary for the proper functioning of the durable medical equipment.

Prostheses We provide benefits for prostheses. Prostheses include artificial limbs and prosthetic appliances. Please refer to the "Exclusions" section for additional information.

Emergency Care in a Foreign Country In emergency situations, you should seek immediate medical attention. Anthem Blue Cross and Blue Shield covers emergency services necessary to screen and stabilize only if a prudent lay person acting reasonably would have believed that an emergency medical condition existed.

Benefits are provided for inpatient and outpatient emergency services in a foreign hospital. If you receive emergency care in a hospital outside the United States and Medicare does not provide benefits, benefits are provided at 100% of the reasonable charges for hospital services received during your stay in a semiprivate

room for the first 121 days. For care after 121 days, benefits are provided at 80% after the deductible. If you stay in a private room that is not medically necessary, we will pay benefits only up to the hospital's most common semiprivate room charge.

In some instances, Medicare will not cover services by a professional in a hospital outside the United States. When this is true and the hospitalization is for emergency care, we will provide benefits for professional emergency care services.

Family Planning We provide benefits for family planning. See the "Contraceptives" provision within this section for details.

Hearing Care We provide Benefits for wearable hearing aids for covered Members up to age 18. Coverage is limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

Hospice Care Services We provide benefits for hospice care services furnished in your home by a home health agency to a member who is terminally ill and the member's family. A member who is terminally ill means a person who has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course.

We provide benefits for hospice care services by a home health agency up to 24 hours during each day of care. Hospice care services are provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Prior approval is required when care exceeds eight hours a day. In this case, the agency must submit a plan of care to receive approval. The agency must then submit a plan of care every 14 days to maintain approval. To be eligible for hospice care services, the patient need not be homebound or require skilled nursing services. Coverage for hospice care services is provided in either a home or inpatient setting.

Hospice care services include but are not limited to: physician services, nursing care, respite care, medical and social work services, counseling services, nutritional counseling, pain and symptom management, medical supplies and durable medical equipment, occupational, physical or speech therapies, home health care services, volunteer services and bereavement services.

Hospice Respite Care We provide benefits for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member of other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide hospice care.

Before the patient receives respite care at home, a home health agency must submit a plan of care for approval. Prior approval is also required when respite care is provided by an inpatient hospice.

Inpatient Hospice Services We provide benefits for inpatient hospice care at an acute care hospital or skilled nursing facility. The same services are covered for inpatient hospice care as are covered under inpatient hospital services.

Inborn Errors of Metabolism We provide benefits for metabolic formula and up to $3,000 per member per calendar year for special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by inborn errors of metabolism.

Infant Formula We provide Benefits for amino acid-based elemental infant formula for children 2 years of age and under when a covered Provider has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. A covered Provider may be required to confirm and document ongoing medical necessity at least annually.

Benefits for amino acid-based elemental infant formula will be provided without regard to the method of delivery of the formula.

Benefits are provided when a covered Provider has diagnosed and through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;
- Laboratory – or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis;
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
- Cystic fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula.

Manipulative Therapy We provide benefits for up to 25 visits per person per calendar year for treating acute musculo-skeletal disorders. We additionally provide Benefits for ancillary treatment, such as massage therapy, heat, and electro-stimulation, when performed in conjunction with an active course of chiropractic or manipulative treatment. Such ancillary treatment may be subject to a deductible, based on service codes billed by the provider. Each type of service may be subject to different or multiple limits and/or other cost share, including copayments. We do not provide Benefits for Maintenance Therapy for chronic conditions.

Mental Health and Substance Abuse Services – Professional

We provide benefits for only the following mental health and substance abuse services when they are for the active treatment of mental health and substance abuse disorders. These services must be part of an established plan of treatment and must be performed and independently billed by a professional acting within the scope of his or her license.

You will receive maximum benefits for mental health and/or substance abuse services when you receive care from network providers.

- Individual and group counseling;
- Family counseling;
- Psychological testing;
- Diagnostic and evaluation services;
- Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring an immediate and acute need for treatment;
- Intervention and assessment.

Mental Health and Substance Abuse Services - Provider We provide benefits for inpatient, outpatient, and day treatment services for mental health and substance abuse when you receive them from a provider.

If you receive provider services from a community mental health center or substance abuse treatment facility, services must be:

- Supervised by a licensed physician, licensed clinical psychologist, or licensed clinical social worker; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

We provide benefits for only the following mental health and/or substance abuse treatment services:

- Room and board, including general nursing;
- Prescription drugs, biologicals, and solutions administered to inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic and evaluation services;
- Intervention and assessment;
- Facility-based professional and ancillary services;
- Individual, group and family counseling;
- Psychological testing;
- Emergency treatment for the sudden onset of a mental health or substance abuse condition requiring immediate and acute treatment.

Obstetrical Services and Newborn Care We provide benefits for prenatal and postnatal care, delivery of a newborn, care of a newborn, and complications of pregnancy. We do not provide benefits for routine circumcisions.

Parenteral and Enteral Therapy We provide benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

Physical and Occupational Therapy We provide benefits for short-term physical and occupational therapy on an outpatient basis for conditions that are subject to significant improvement. Services are covered only when provided by a licensed professional acting within the scope of his/her license.

No benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

Prescription Drugs

We provide benefits under your prescription drug card program for FDA approved prescription drugs and medicines bought for use outside a hospital. The Covered Drug Copayment or Coinsurance may vary based on whether the Prescription Drug has been classified by Anthem as a Tier 1, Tier 2, or Tier 3 Drug.

Anthem BCBS/WellPoint, Inc. has established the WellPoint National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignment of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determination of tiers is made by Anthem BCBS/WellPoint based upon clinical decisions provided by the National P & T Committee, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives, and where appropriate, certain clinical economic factors.

You may review a copy of the current tier listing online at: www.anthem.com or you may request a copy of the tier listing by calling a customer service representative at the number of the back of your ID card. The tier listing is subject to periodic review and amendment. Inclusion of a drug or related item on the tier listing is not a guarantee of coverage. Refer to the prescription drug Benefit sections in this Certificate for information on coverage, limitations and exclusions**.**

We retain the right to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another Tier.

- Tier 1 drugs have the lowest copayment. This tier will contain low cost and preferred medications that may be generic, single source brand drugs, or multi-source brand drugs.
- Tier 2 drugs will have a higher copayment than those in tier 1. This tier will contain preferred medications that may be generic, single source, or multi-source brand drugs.
- Tier 3 drugs will have a higher copayment than those in tier 2. This tier will contain non-preferred and high cost medications. This will include medications considered generic, single source brands, or multi-source brands.

From time to time we may initiate various programs to encourage covered persons to utilize more cost effective or clinically-effective drugs including, but not limited to, generic drugs, mail order drugs, OTC, or preferred products. Such programs may involve reducing or waiving copayments or coinsurance for certain drugs or preferred products for a limited period of time.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require prior authorization of benefits. Prior authorization helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit coverage. At the time you fill a prescription, the network pharmacist is informed of the prior authorization requirement through the pharmacy's computer system and the pharmacist is instructed to contact the pharmacy benefits manager (PBM). The PBM is a pharmacy benefit management company with which we contract to manage your pharmacy benefits. Please see the "Benefit Determinations, Payments and Appeals" section for additional information.

The PBM uses pre-approved criteria, developed by Anthem's national Pharmacy and Therapeutics Committee and reviewed and adopted by Anthem. The PBM communicates the results of the decision to the pharmacist. The PBM may contact your prescribing physician if additional information is required to determine whether prior authorization should be granted. If prior authorization is denied, you have the right to appeal through the appeals process outlined in the "Benefit Determinations, Payments and Appeals" section of this certificate.

Please note one exception to the prior authorization requirement. When the prior authorization is initiated but cannot be completed, Anthem may authorize coverage for a sufficient amount of the Prescription Drug which will provide the additional time for Anthem to make the prior authorization decision.

For a list of current drugs requiring prior authorization, please contact a customer service representative at the number on the back of your ID card or consult the website at **www.anthemprescription.com.** The tier listing is subject to periodic review and amendment. Inclusion of a drug or related item on the tier listing is not a guarantee of coverage.

Continuity of Prescription Drugs

We reserve the right to request a review of your previous insurance carrier's prescription drug prior authorization with your prescribing provider. If your provider participates in the review and requests that the prior authorization be continued, we will honor the previous insurance carrier's prior authorization for a period not to exceed 6 months beginning with your effective date of coverage with us.

The cost share requirements of this plan will apply. We do not provide benefits for conditions or services not otherwise covered under this certificate.

Prescription Drugs From A Retail Pharmacy When your prescription is filled at a retail Pharmacy, you pay the amount shown on your Schedule of Benefits. Certain participating retail pharmacies can fill your prescription at the same Copayments that apply to the mail order Pharmacy. Please ask your Pharmacy if they participate in this special arrangement or call our Customer Service Department at the number on your ID card for a list of participating pharmacies.

Prescription Drugs By Mail Your Contract may allow you to obtain Prescription Drugs by mail. To obtain Benefits for Prescription Drugs by mail, complete a mail order Pharmacy form, available through our Customer Services Department, and mail it with your prescription. You must pay the applicable Copayment amount indicated on your Schedule of Benefits.

Changes In Your Prescription Your pharmacist may check your prescription to determine if there may be harmful interactions between the prescription you are filling and any other prescription you may be taking. The pharmacist may contact your Physician to discuss possible changes to your prescription.

Refills on Prescriptions Your Physician will indicate the number of refills for your prescription. We will cover the refill for your prescription when you have taken 85% of the medication, based on the dosage schedule prescribed by the Physician. We will not provide Benefits for refills that are filled sooner.

Maintenance Prescription Supplies Benefits are provided for up to a 90-day supply if prescribed by your Physician as medically appropriate. Please refer to your Schedule of Benefits for Copayment amounts that apply to you.

Step-Therapy Protocol Screening For many conditions, the FDA has approved more than one medication for use. These include first-line medications customarily utilized to treat the condition and second-line medications. Second-line medications may be prescribed for patients who have utilized a first-line medication for their condition which has not been completely effective or for patients that may experience side effects with the first-line medication. We will provide Benefits for certain second-line medications only after you have previously attempted to use an appropriate first-line medication and it was not completely effective or it would result in complications or side-effects.

Therapeutic Substitution of Drugs Your Pharmacy benefit includes a therapeutic drug substitution program approved by Anthem and managed by the PBM. This voluntary program is designed to inform Members and Physicians about tiering alternatives. The PBM may contact the Member**,** the Member's representative, or the prescribing Physician to make the Member aware of tiering substitution options. Only the Member and the Member's Physician can determine whether the therapeutic substitution is appropriate.

Half-Tablet Program The Half-Tablet Program will allow Members to pay a reduced copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "1/2 tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member's decision to participate should follow consultation with and the concurrence of his/her Physician. To obtain a list of the products available on this program call the Customer Service number on the back of your ID card.

Vacation Supplies If you are going out of the area for an extended period of time and your supply of medications is not sufficient for this period, you may contact your Pharmacy or the prescribing Physician

prior to leaving the area to receive an early refill or an extended-day supply of medications while you are away from home. Controlled substances are excluded from this program.

Specialty Pharmacy Network You or your physician can order Specialty Drugs directly from any Network, Specialty Network or Non-Network Pharmacy. If you or your physician orders your Specialty Drugs from a Specialty Participating Pharmacy you will be assigned a patient care coordinator who will work with you and your Physician to obtain Prior Authorization and to coordinate any shipping of your Specialty Drugs directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

Specialty pharmacies may fill retail and mail service Specialty Drug prescription orders, subject to a 30-90 day supply. The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, including a Network Specialty Pharmacy, a Non-Network Pharmacy, or a mail order vendor. You may obtain a list of specialty drugs available through the Specialty Pharmacy Network by contacting the Customer Service number on the back of your ID card, or by visiting our website www.anthem.com.

A list of participating Specialty Pharmacies is available by contacting the Customer Service number on your ID card, or by visiting our website www.anthem.com.

Preventive and Well-Care Services

Preventive Care services include, Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Plan with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider]. That means the Plan pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

   a. Breast cancer;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

    a. Women's contraceptives, sterilization procedures, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the Prescription Drug benefit.

    b. Breastfeeding support, supplies, and counseling.

    c. Gestational diabetes screening.

You may call Customer Service using the number on your ID card for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.)

Reconstructive Surgeries, Procedures and Services Benefits are available for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

1. necessary due to accidental injury; or
2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
3. Medically Necessary Health Care to restore or improve a bodily function, or
4. necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate
5. for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Certificate.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to Anthem Medical Policy coverage criteria.

Some examples of reconstructive surgeries, procedures and services eligible for consideration based on Anthem Medical Policy coverage criteria are:

1) Mastectomy for Gynecomastia
2) Mandibular/Maxillary orthognathic surgery
3) Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants
4) Port Wine Stain surgery

Speech Therapy We provide benefits for short-term speech therapy on an outpatient basis for conditions that are subject to significant improvement. Services are covered only when provided by a licensed professional acting within the scope of his/her license.

Benefits are limited to 40 visits of speech therapy services per calendar year. No benefits are provided for:

- Deficiencies resulting from mental retardation; or

- Dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Stockings Benefits are provided for Jobst stockings for post-surgical use or when prescribed for circulatory diseases.

Telemedicine Benefits are provided for telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a covered health care provider. Coverage for health care services provided through telemedicine will be determined in a manner consistent with coverage for health care services provided through in-person consultation.

Varicose Vein Surgery

Benefits are provided for medically necessary varicose vein surgery. Cosmetic surgery is not covered.

Section Five
Exclusions

This section, along with the "Covered Services" sections, explain the types of health care services we will and will not provide benefits for. The exclusions listed below are in addition to those set forth elsewhere in this Certificate. Charges you pay for services related to non-covered services do not count toward any deductible, coinsurance, or out-of-pocket limits.

Alternative Medicines or Complementary Medicines We do not provide benefits for alternative or complementary medicine. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven or established, as determined by Anthem Blue Cross and Blue Shield's Medical Director. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless otherwise stated in the Covered Services section), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

Artificial Hearts We do not provide benefits for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a heart transplant.

Benefits Available from Other Sources We do not provide benefits for any services to the extent that there is no charge to you or to the extent that you can recover expenses through a federal, state, county, or municipal law. This is the case even if you waive or fail to assert your rights under these laws. However, this exclusion does not apply to Medicaid.

Biofeedback We do not provide benefits for biofeedback.

Blood We do not provide benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

Cosmetic Services We do not provide benefits for cosmetic services intended solely to change or improve appearance, or to treat emotional, psychiatric or psychological conditions. Examples of cosmetic services include, but are not limited to: surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Benefits will be provided for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Custodial Care We do not provide benefits for services, supplies or charges for Custodial Care, domiciliary or convalescent care, whether or not recommended or performed by a professional.

Dental Services We do not provide benefits for orthognathic surgery, dentistry, dental surgery, dental implants or any other services unless specifically listed as covered in Section 3.

Department of Veterans Affairs We do not provide benefits for any treatments, services, or supplies provided to veterans by the Department of Veterans Affairs, its hospitals, or facilities if the treatment is related to your service connected disability.

Experimental/Investigational Services We do not provide benefits for any drugs, supplies, providers, medical, or health care services that are experimental/investigational. This exclusion includes the cost of all services from a provider or professional including the cost of all services while you are an inpatient receiving an experimental/investigational service or surgery. Drugs classified as Treatment Investigational New Drugs (IND) by the FDA and devices with the FDA Investigational Device Exemption (IDE), any device to which the FDA has limited access or otherwise limited approval, and any services involved in clinical trials (except as otherwise indicated in section 3) are considered experimental/investigational.

Facilities of the Uniformed Services We do not provide benefits for any treatments, services, or supplies provided by or through any health care facility of the uniformed services. This exclusion does not apply if you are a military dependent or retiree.

Family Planning Services We do not provide benefits for services to reverse voluntarily induced sterility; non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices.

Genetic Testing and Counseling We do not provide Benefits for genetic counseling, except as required by law. We do not provide Benefits for genetic testing, except in accordance with WellPoint Medical Policy. Medical technology is constantly evolving and medical policies are subject to change without notice.

Government Institutions We do not provide benefits for any services provided to you by any institution that is owned or operated by the federal government or any state, county, or municipal government.

Hearing Care We do not provide Benefits for hearing examinations. Please see the "Hearing Care" provision in the Covered Services section for benefits for hearing aids.

Infertility We do not provide benefits for diagnostic services, procedures, treatment or other services related to infertility. This exclusion also applies to drugs used to enhance fertility. We do not provide benefits for costs associated with achieving pregnancy through surrogacy.

Leased Services and Facilities We do not provide benefits for any health care services or facilities that are not regularly available in the provider you go to, that the provider must rent or make special arrangements to provide, and that are billed independently.

Maintenance Therapy We do not provide benefits for maintenance services, treatments or therapy.

Major Disaster, Epidemic, or War In the event of a major disaster, epidemic, war (declared or undeclared), or other circumstances beyond our control, we will make a good faith effort to provide or arrange for covered services. We will not be responsible for any delay or failure to provide services due to lack of available facilities or personnel. Benefits are not provided for any disease or injury that is a result of war, declared or undeclared, or any act of war.

Medically Unnecessary Services We do not provide benefits for any treatment, services, or supplies that do not meet the definition of medically necessary health care.

Medicare We may not provide benefits for costs covered by Medicare. This Plan does not duplicate Medicare benefits.

Mental Health, Substance Abuse Treatment, and Lifestyle Services We do not provide benefits for any of the following services or any services relating to:

- Smoking clinics;
- Sensitivity training;
- Encounter groups;
- Educational programs except as indicated in the "Covered Services Additional Services" section;
- Marriage, guidance, and career counseling;
- Codependency;
- Adult Children of Alcoholics (ACOA);
- Pain control (except as required by law for hospice care services);
- Activities whose primary purpose is recreational and socialization;

Miscellaneous Expenses We do not provide benefits for provider or professional charges to provide required information to process a claim or application for coverage. We do not provide benefits for any additional costs associated with an appeal of a claim decision.

Missed Appointments We do not provide benefits for missed appointments. Providers and/or professionals may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No benefits are available for these charges. You are solely responsible for these charges.

Orthognathic Surgery We do not provide benefits for orthognathic surgery, except as stated in the Covered Services, Reconstructive Surgeries, Procedures and Services section.

Orthotic Devices We do not provide benefits for orthotic devices unless stated as covered in Section 3 - Additional Services in this contract.

Personal Comfort Items We do not provide benefits for any personal comfort items such as television rentals, newspapers, telephones, and guest meals.

Physical and Occupational Therapy We do not provide benefits for massage therapy, treatment such as paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

Prescription Drugs We do not provide benefits for the following:

- Any refill in excess of the number specified by the physician or for refills dispensed after one year from the date of original prescription order;
- Non-prescription vitamins, prescription and non-prescription multivitamins (other than prescription prenatal vitamins for perinatal care), cosmetics, dietary supplements, health or beauty aids, dermatologicals used for cosmetic purposes, topical dental fluorides;
- Nonlegend (over-the-counter) prescriptions, including but not limited to, prescriptions for which there is an over-the-counter (OTC) equivalent in both strength and dosage form;
- Prescription drugs for the treatment of weight reduction/anorectics;
- Medication that is taken by or administered to an inpatient;

- Experimental or investigational drugs or any Food and Drug Administration (FDA) Treatment Investigational New Drugs (IND), unless the intended use of the drug is included in the labeling authorized by the federal Food and Drug Administration or if the use of the drug is recognized in one of the standard reference compendia or in peer-reviewed medical literature;
- Disposable supplies such as alcohol, cotton balls, or bandages used to administer medications;
- Prescription drugs dispensed by a physician;
- Prescription drugs used to enhance fertility;
- Prescription drugs approved by the federal Food and Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.

Preventive Care We do not provide benefits for preventive care services, unless otherwise stated in Sections 2 or 3.

Prostheses We do not provide benefits for dental prostheses, or prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes.

Refractive Eye Surgery We do not provide benefits for refractive eye surgery, such as radial keratotomy, for conditions that can be corrected by means other than surgery.

Reverse Sterilization We do not provide benefits for services to reverse voluntarily induced sterility.

Routine Circumcisions We do not provide benefits for routine circumcisions.

Routine Foot Care We do not provide benefits for any services rendered as part of routine foot care.

Services After Your Contract Ends We do not provide benefits for services that are provided after your contract ends unless your group cancels coverage with Anthem BCBS and you are an inpatient on the group cancellation date. If you are an inpatient on the date your group cancels coverage with Anthem BCBS and you have care after the date your group coverage ends and your group has replacement coverage, the replacement carrier pays primary benefits for the inpatient care provided after the effective date and this Plan pays secondary benefits. If there is no replacement carrier, this Plan pays primary benefits. Benefits under this Plan will end when you are no longer disabled, when you reach any contract maximums, when you are discharged as an inpatient and you are no longer disabled, or six months from the termination of your group contract, whichever occurs first.

Services Before the Effective Date We do not provide benefits for any treatment, services, supplies, medical equipment, or prostheses rendered to you or received before your individual effective date of coverage. Services you receive during an inpatient stay that started before you enrolled are covered only as of your effective date on this contract. For an inpatient stay, care that is provided before your effective date is not covered.

Services by Ineligible Providers or Professionals We do not provide benefits for services provided by any provider or professional not listed as an eligible provider or professional in this contract.

Services by Relatives or Volunteers We do not provide benefits for any services provided in any capacity by immediate family members or step-family members, for example, spouse, domestic partner, father, mother, brother, sister, son or daughter. We do not provide benefits for services by volunteers, except as outlined in the "Hospice Care Services" provision.

Services Not Listed As Covered We do not provide benefits for any service, procedure, or supply not listed as a covered service in this contract.

Services Related to Non-Covered Services We do not provide benefits for services related to any non-covered service or to any complications and conditions resulting from any non-covered service.

Sex Changes We do not provide benefits for any services related to any transsexual operation.

Speech Therapy We do not provide benefits for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Temporomandibular Joint (TMJ) Syndrome Services We do not provide benefits for surgical and non-surgical examination; diagnosis, including invasive (internal) and non-invasive (external) procedures and tests; and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-covered services include but are not limited to: physiotherapy, such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound, or diathermy; behavior modification such as biofeedback, psychotherapy; appliance therapy such as occlusal appliances (splints) or other oral prosthetic devices and their adjustments; orthodontic therapy such as braces; prosthodontic therapy such as crowns, bridgework; and occlusal adjustments.

Travel Expenses We do not provide benefits for any travel expenses, whether or not the travel is recommended by a professional.

Vision Care We do not provide benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises. We do not provide benefits for the prescription, fitting, or purchase of glasses or contact lenses except when medically necessary to treat accommodative strabismus, cataracts, or aphakia.

Weight Reduction Programs We do not provide benefits for weight reduction programs.

Workers' Compensation We do not provide benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs.

We will pay benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met**:

- You are making a claim under the Workers' Compensation Act;
- Your health care coverage is provided through an employee health plan;
- Your employer or your employer's workers' compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
- The Workers' Compensation Board has not made a determination on your claim;
- Your employer has made no payment on or settlement of your claim.

Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this Plan, as stated in Section 5.

Section Six
Benefit Determinations, Payments and Appeals

This section explains how Anthem Blue Cross and Blue Shield pays benefits for covered services. Anthem Blue Cross and Blue Shield reserves the right to pay benefits to another person if so ordered by a court of competent jurisdiction.

Benefit Determinations

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms of the contract. However, we, or anyone acting on our behalf will determine the administration of your benefits. Our 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, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowance. However, you may utilize all applicable Complaint and Appeal procedures, as outlined later in this section.

You may have some responsibility for the cost of health services under your contract. Your responsibility may take the form of a coinsurance percentage, a deductible, or a copayment amount. Please see your Schedule of Benefits for the coinsurance, deductible and copayment amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your coinsurance, deductible, or copayment amount directly to the professional or hospital or other provider of care. If you have coinsurance responsibility that is based on a percentage, you will pay your coinsurance percentage based on the hospital's or provider's discounted charge or negotiated amount, or our Maximum Allowance for professionals. **Note**: We cannot prohibit non-network providers from billing you for the difference in the non-network provider's charge and the Maximum Allowance. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies.

All benefits for covered services will be based on any discounted charge for hospital service or our Maximum Allowance for professional services.

We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, prescription drugs, mental health, behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Anthem BCBS Medical Policy

The purpose of medical policy is to assist in the interpretation of medical necessity. However, the Certificate of Coverage and the Group Agreement take precedence over medical policy. Medical technology is constantly changing and we reserve the right to review and update medical policy periodically.

Contract Changes

We may change this contract at any time provided the changes are in accordance with all applicable laws and we give the group thirty days of notice. After we notify the group of a change, payment of billed charges indicates the group's and your acceptance of the change. The group is responsible for notifying the subscriber of any contract changes.

Compliance with Laws
If federal laws or the laws of the state of Maine change, the provisions of this contract 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 laws of the state of Maine will not be rendered invalid, but will be construed and applied as if it were in full compliance.

Confidentiality
Any information pertaining to your diagnosis, treatment or health obtained from either your physician, provider, or us will be held in confidence. We may reveal this information only to the extent required or permitted by law.

Statements and Representations
The statements you make on your application for coverage with us are representations and not warranties.

Annual Reports
Annual reports are prepared and made available to all subscribers. The annual report contains information about our activities including audited financial statements.

Severability
If any term or provision in this Certificate is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

How Your Deductible Works
Most covered services described in the "Additional Services" section are subject to a deductible. A deductible is the amount you must pay toward the cost of covered services before we provide benefits. Please refer to your Schedule of Benefits for the deductible amount that applies.

Each calendar year, before benefits can be paid, you must satisfy your deductible.

> **Example:** Your first service of the year is for an office visit for sick care to a participating physician. The charge is $65. If the Plan would have paid $50 for that service, $50 will be applied to your deductible. Your responsibility to the provider is $50.

When you receive covered services during the last three months of the calendar year and the charges for these covered services are applied toward that year's deductible, except for mental health and substance abuse services, then these same charges will also be applied toward the deductible for the following year.

Copayments and Coinsurance
Copayments and coinsurance apply after you have satisfied your deductible. Please see your Schedule of Benefits for copayment amounts and coinsurance amounts and limits. If services are received from a provider that does not have a written participation agreement with us, there may be instances in which you may be responsible for any remaining balances beyond the Maximum Allowance in addition to any applicable coinsurance or deductible, unless we authorize these services due to Network inadequacy. We cannot prohibit non-network providers from billing you for the difference in the non-network provider's charge and the Maximum Allowance.

Copayments For some services, your share of the cost is a fixed dollar amount. Copayment amounts do not count toward any coinsurance or out-of-pocket limits under this contract. You must pay the copayment at the time you receive the covered service.

Coinsurance For some provider and professional services described in the "Additional Services" section, your share of the cost is a percentage, which is limited to an annual dollar amount. This is the coinsurance amount.

Once you meet the annual individual coinsurance limit we will pay benefits at 100% of the provider's charge or negotiated amount or the Maximum Allowance for professional services for the rest of the calendar year, up to the lifetime maximum for all covered services when care is provided by network providers or professionals. Mental health services and services provided by non-participating providers or professionals will be reimbursed at the levels specified in your Schedule of Benefits or contract up to any benefit or lifetime maximum.

If you have coinsurance responsibility that is based on a percentage, you will pay your coinsurance percentage based on the hospital's or provider's discounted charge or negotiated amount, or our Maximum Allowance for professionals.

Our payment will consist of a percentage of our Maximum Allowance after any copayments and deductibles have been applied.

Out-of-Pocket Limits

Your Additional Services annual out-of-pocket expenses for your deductible and coinsurance are limited. Please refer to your Schedule of Benefits for annual out-of-pocket limits. Once you reach the annual out-of-pocket limit, no further deductibles or coinsurance apply for the remainder of the calendar year. Copayment amounts continue to apply after the coinsurance limit is met.

Lifetime Maximums

Your contract has a limit on the maximum amount for which we are responsible during the lifetime of any covered member. The amount of the lifetime maximum is stated on your Schedule of Benefits. All benefit amounts for which we are responsible, over and above your coinsurance payments, are accumulated toward your lifetime maximum under your contract. Once benefit amounts equal to the lifetime maximum have been accumulated, we will not be liable for any further payments for covered services you incur.

Benefit Maximums

Specific benefit maximums for each covered member apply for some services. These maximums are listed on your Schedule of Benefits or in the Certificate.

Mental Health

All benefits for mental health covered services counted toward any maximums will be based on any discounted charge for hospital services or our maximum allowance for professional services.

Benefit Payments

Claims Procedure

How to Claim Benefits In most instances, providers will file your claims with us. However, you may need to submit a claim for reimbursement for services from non-participating providers.

To receive claim forms, contact your group or call our Customer Service Department. When you submit your claim, please include originals of all of your bills and retain a copy for your files.

Time Limit for Filing Claims We must receive proof of a claim for reimbursement for a covered service no later than 3 years after that service is received. We recognize that there may be special circumstances which would prevent a claim from being submitted within the 3-year time limit. Claims denied for timely filing may be reviewed through the member appeal process, which will consider whether the claim was filed as soon as reasonably possible.

Releasing Necessary Information Providers often have information we need to determine your coverage. As a condition for receiving benefits under this contract, you or your representative must give us all of the medical information we need to determine your eligibility for coverage or to process your claim.

Non-Transfer of Benefits Your benefits under this contract are personal to you. You cannot assign or transfer them to any other person.

Assignment of Payments You may assign benefits provided for covered services to the provider of the care.

Non-Compliance If we do not enforce compliance with any provision of this contract, we are not required to allow non-compliance with that provision or any other provision at any time, in any case.

Examination of Insured To ensure that all claims are valid, we may require the member to have a physical or mental examination at our expense.

Claims Payment

This explains how benefits for covered services will be paid. We reserve the right to pay benefits to another person if so ordered by a court of competent jurisdiction. You have the right to appeal as outlined later in this section.

In most cases providers are required by law to file claims for you to Medicare. To have Medicare send information on claims directly to Anthem Blue Cross and Blue Shield, please give the provider or professional your Group Companion Plan certificate number along with your Medicare HIC number. You will receive an Explanation of Medicare Benefits (EOMB) from Medicare which will describe payments they have made. Please keep your EOMB. We may request a copy of your EOMB to get the information we need to process some claims. If we need a copy of your EOMB we will ask for it on the Group Companion Plan Explanation of Benefits (EOB) which we will send you.

Basic Services

If you receive Medicare-approved, covered Basic Services from:

- A Medicare-contracting hospital or any other Medicare-contracting facility, we will pay the facility directly.
- A non-contracting hospital or other facility, we will decide whether to pay you or the facility, subject to your assignment rights outlined above.
- A professional or supplier who accepts Medicare assignment, we will pay the provider or supplier.
- A professional or supplier who does not accept Medicare assignment, we will pay you, subject to your assignment rights outlined above.

Additional Services

We generally pay specialists and professionals for each service they provide, based on a Maximum Allowance.

The Maximum Allowance for a service is determined based upon the resources needed to provide a given service. The resources taken into account are a provider's or professional's total work, practice costs, and malpractice costs which are added together. The total is multiplied by a common scale monetary conversion factor to establish the Maximum Allowance. Our payment will be based on the most cost effective means that can safely be administered. You can contact us to find out the Maximum Allowance for a service by calling the telephone number on your ID card.

We generally pay providers in several different ways. These ways may include discounts from regular charges and fixed fees.

Payment of Provider Services

Network Providers If your claim from a network provider is approved, benefits will be paid directly to the provider. Our payment will be based on the most cost effective means that can be safely administered. Except for copayments, you are not required to pay any balances to the provider until after we determine the benefits we will pay. Network providers who render covered services that are based on a Maximum Allowance agree to limit their charges to the Maximum Allowance.

Non-Network Providers If you receive covered services or supplies from a provider that does not have a written participation agreement with us, we will decide if we will pay benefits. We will base this decision on factors such as the provider's ability to meet certain standards for licensure and expertise to meet the needs of the member. Our payment will be based on the most cost effective means that can be safely administered. If we do approve your claim, benefits will be paid at the non-network level listed on your Schedule of Benefits. We will pay benefits directly to you or the provider. We cannot prohibit non-network providers from billing you for the difference in the non-network provider's charge and our Maximum Allowance.

Payment for Professional Services

Network Professionals If your claim from a network professional is approved, benefits will be paid directly to the professional. Our payment will be based on the most cost effective means that can be safely administered. Except for copayments, you are not required to pay any balances to the professional until after we determine the benefits we will pay. Network professionals who render covered services that are based on a Maximum Allowance agree to limit their charges to the Maximum Allowance unless you and the professional make prior arrangements.

Your network professional's agreement for providing covered services may include financial incentives or risk sharing relationships related to provision of services or referrals to other professionals, including network professionals and non-network professionals and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your professional or us.

Non-Network Professionals If you receive covered services or supplies from a professional that does not have a written agreement with us, we will decide if we will pay benefits. We will base this decision on factors such as the professional's ability to meet certain standards for licensure and expertise to meet the needs of the member. Our payment will be based on the most cost effective means that can be safely administered. If we do approve your claim, benefits will be at the non-network benefit level. We will pay benefits directly to you. However, if you receive emergency room care, we will not reduce the benefits. We cannot prohibit non-network professionals from billing you for the difference in the non-network professional's charge and our Maximum Allowance.

Provider and Professional Payment Methods

We generally pay specialists and professionals for each covered service they provide, based on a Maximum Allowance. The Maximum Allowance for a service is determined based upon the resources needed to provide a given service. The resources taken into account are a professional's total work, practice costs, and malpractice costs which are added together. The total is multiplied by a common scale monetary conversion factor to establish the Maximum Allowance. Our payment will be based on the most cost effective means that can safely be administered. You can contact us to find out the Maximum Allowance for a service by calling the telephone number on your ID card.

We generally pay providers in several different ways. These ways may include discounts from regular charges and fixed fees.

Out-of-State Providers

We cannot prohibit out-of-state providers from billing you any balance remaining after we have made our payment based on the maximum allowable amount, except as otherwise provided under the BlueCard program.

Inter-Plan Programs

Out-of-Area Services

Anthem BCBS has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem BCBS service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem BCBS and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem BCBS service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare providers. Anthem BCBS payment practices in both instances are described below.

BlueCard® Program

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

Whenever you access covered healthcare services outside Anthem BCBS service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments,

and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

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

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

Under certain circumstances, if **we** pay the healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, **we** may collect such amounts directly from you. You agree that **we have** the right to collect such amounts from you.

Non-Participating Healthcare Providers Outside Anthem BCBS Service Area

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

Exceptions

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

Hospitals Outside of the United States

We provide benefits for inpatient and outpatient services in a foreign hospital. If you obtain covered services outside of the United States, in most cases, you will have to pay your bill when you leave the hospital.

When you return home, send the following to us with your claim form:

- A statement of the nature of the illness or injury;
- An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- Your contract number; and
- The dollar rate of exchange at the time you received the service(s), if possible.

When we receive this information, we will reimburse you for covered services according to the terms of this contract.

Pharmacy Benefit Management

The Pharmacy Benefits available to you under this Plan are managed by a pharmacy benefits management (PBM) company with which we contract to manage your Pharmacy Benefits. The PBM has a nationwide network of retail pharmacies, a mail service Pharmacy, and clinical services that include tier management.

The management and other services provided include, among others, making recommendations to, and updating, the tier listing and managing a network of retail pharmacies and operating a mail service Pharmacy. The PBM, in consultation with Anthem, also provides services to promote and enforce the appropriate use of Pharmacy Benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns.

Payment for Prescription Drug Claims

To obtain Benefits for Prescription Drugs, present your identification card to any Pharmacy that has an agreement with the PBM, in this or any other state. You must pay the applicable amounts shown on your Schedule of Benefits. The participating Pharmacy will submit the claim for you and the PBM will directly pay the Pharmacy the balance due. Please call Customer Service at the telephone number on your ID card if you have questions about the participation status of a Pharmacy.

If you use a Pharmacy that does not have an agreement with the PBM, or if you do not use your identification card, you must pay the Pharmacy the entire cost for the prescription and submit a claim form for reimbursement. Claim forms are available by contacting a Customer Service Representative.

If you receive Prescription Drugs from a non-participating Pharmacy or if you do not use your identification card, you may receive a reduced benefit. We will reimburse you based on the amount we would have paid to a participating Pharmacy less your share of the cost.

Your financial responsibility (Copayments) will not be reduced by any discounts, rebates or other funds received by the Pharmacy Benefits Manager from drug manufacturers, or similar vendors or funds received by the plan from the Pharmacy Benefits Manager.

Your prescription drug Copayment will be the lesser of your scheduled Copayment amount or the retail price charged for your prescription by the Pharmacy or the Pharmacy Benefits manager that fills your prescription.

No payment will be made by us for any Covered Service unless our negotiated rate exceeds any applicable Copayment for which you are responsible.

Prescription Drugs By Mail

To obtain Benefits for Prescription Drugs through the mail order Pharmacy, complete a mail order Pharmacy form, available through our Customer Service Department, and mail it with your prescription. You must enclose the applicable Copayment amount indicated on your Schedule of Benefits.

Coordination of Benefits

All benefits of the contract are subject to coordination of benefits (COB). COB is a formula that determines how benefits are paid to members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total benefits you receive from all contracts do not exceed the cost of covered services.

COB sets the payment responsibilities for any contract that covers you, such as:

- Group, individual (also known as non-group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- Other insurance that provides medical benefits.

The contract with primary responsibility provides full benefits for covered services as if there were no other coverage. The contract with secondary responsibility may provide benefits for covered services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. All benefits are limited to the contract maximums or to the Maximum Allowance for the services you receive.

When you have duplicate coverage, we will determine benefits by using the first of the following rules that applies:

- If the other contract does not contain a COB clause or does not allow coordination of benefits with this contract, the benefits of that contract will be primary;
- If both contracts contain a COB clause allowing the coordination of benefits with this contract, we will determine benefit payments by using the first of the following rules that applies:

1. **Non-Dependent/Dependent** The benefits of the contract that covers you as an employee or subscriber will be determined before the benefits of the contract that covers you as a dependent are determined.
2. **Dependent Children (Parents Not Legally Separated or Divorced)** For claims on covered dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this contract will determine the order of benefits.
3. **Dependent Children (Parents Legally Separated or Divorced)** In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the dependent's health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.
4. **Active/Inactive Employee** The benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of benefits, rule six applies.

5. **Continuation of Coverage** If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or subscriber, or as the dependent of an employee or subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule six applies.
6. **Longer/Shorter Length of Coverage** If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

We reserve the right to:
- Take any action needed to carry out the terms of this provision;
- Exchange information with an insurance company or other party;
- Recover our excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when we decide they're necessary without notifying the covered persons.

Credit Toward Deductible
When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

Disability
If your group coverage terminates with us while you are totally disabled, benefits for covered services directly relating to the condition causing total disability remain available to you until you are no longer disabled, you reach any contract maximums, you are discharged as an inpatient and you are no longer disabled, or six months from the termination of your group contract, whichever occurs first.

If you have replacement coverage, the replacement coverage will pay as primary coverage during this time, and we will pay as secondary coverage for the covered expenses directly relating to the condition causing total disability.

Under the contract, disabled means:
- If you were employed, you are unable to work in your regular and customary occupation because of illness or injury;
- If you were not gainfully employed, you are unable to engage in most normal activities of a person of like age in good health.

Our coverage of losses during your total disability has the same limits that apply to employees or members who are not disabled.

Special Information If You Become Eligible For Medicare
You must notify us if you become eligible for premium free Medicare Part A. Failure to notify us could result in retroactive adjustments if Medicare would have been or is the primary payor. You may choose to continue your coverage once you are eligible for premium free Medicare Part A and Medicare Part B until your retirement if you continue to meet the eligibility requirements.

Special rules apply for individuals covered by this Plan who are eligible for Medicare due to end stage renal disease (ESRD). This Plan pays secondary to both Medicare Part A and Part B after the ESRD coordination period. This is true even if you fail to exercise your rights to premium free Medicare Part A and Part B.

If you have Medicare Parts A and B, you may elect COBRA continuation coverage as the result of a qualifying event. Please see the "COBRA" provision in the "Eligibility, Termination and Continuation of Coverage" section for additional information.

If you become entitled to Medicare while you are covered as a COBRA beneficiary, you must notify us, as your eligibility to continue COBRA coverage will end as of the date you become entitled to Medicare.

Subrogation: Payments Resulting from Claim or Legal Action

When another party may have caused or may be responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party. When we provide health care benefits for treatment of your injury or illness, we have the right to recover, from any such payment (whether by judgment, suit, compromise, settlement or otherwise) up to the total benefit we paid, on a just and equitable basis. The process of recovering these expenses is called subrogation.

We also have subrogation rights against your own insurance, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy. Subrogation applies whether any of the payment or settlement is allocated for medical expenses.

If the services related to your illness or injury are covered by a capitation fee, we are entitled to the reasonable cash value of the services.

By accepting coverage you agree:

- Your signed application for coverage is your authorization of our right of subrogation;
- To notify us of any event which could result in legal action, a claim against a third party, or a claim against your own insurance;
- To notify us of any payments you receive as a result of legal action, a claim against a third party, or a claim against your own insurance;
- To cooperate with us in exercising our right of subrogation by providing all information we request;
- To sign documents we deem necessary to protect our rights; and
- To do nothing to interfere with our subrogation rights.

If you do not comply with the above, you may be responsible for expenses we incur in enforcing our subrogation rights.

Complaints and Appeals

Complaints

Our Customer Service Representatives are ready to help Members resolve complaints about claims processing, benefit choices, enrollment, or health care given to you by your Provider. A Customer Service Representative may need to send your complaint to another area for response. The staff that gets the Member complaint will review and quickly give a finding to the Member on the complaint. Anthem will make a good faith effort to get all information quickly. Your Provider may ask by phone, fax or in writing for us to reconsider an adverse determination within one working day after we get the request. The review will be done by the person who made the adverse determination or by a peer if the first person cannot be on hand within one working day.

For first Utilization Review findings, Anthem will make the decision and will let the Covered Person and their Provider know the result within 2 working days after getting all needed information on a proposed hospital stay, treatment or service that calls for a review decision.

If more information is needed, a final decision will be made within thirty (30) days after the added information is received. If your complaint is not resolved to your satisfaction, you may seek help through the Appeal process outlined below. Enrollees may begin a first level Appeal at any time.

Complaints Requiring Immediate Intervention

If you are not happy with a finding on a service, we will work with the health care provider to answer quickly to the concern. This will happen before the need for services, when possible, or within 48 hours after receiving all necessary information.

Concurrent review decisions.
Anthem will make the decision within one working day after getting all needed information.
In the case of a decision to approve a longer stay or more services, Anthem notifies the Member and the Provider rendering the service within one working day. The written notice will include the number of added days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, Anthem notifies the Member and the Provider rendering the service within one working day. The service will continue without liability to the Member until the Member has been told of the finding.

Expedited Appeals.
Anthem has a written process for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures would seriously threaten the life or health of a Member or would risk the Member's ability to get back maximum function. An expedited appeal will be available to, and may be requested by, the Member or the Provider acting for the Member.

Expedited appeals will be reviewed by a clinical peer or peers. The clinical peer/s will not have been part of the first adverse determination.

Anthem will provide expedited review to all requests for a hospital stay, availability of care, continued stay or health care service for a Member who has received emergency services but has not been discharged from a facility.

In an expedited review, all needed information, including Anthem finding, will be shared between Anthem and the Member or the Provider acting for the covered person by telephone, facsimile, electronic means or the quickest method available.

In an expedited review, Anthem will make a decision and notify the Member and the Provider acting for the Member by phone as quickly as the Member's medical condition requires, but not more than 72 hours after the review is begun. If the expedited review is a concurrent review decision of emergency services or of an initially authorized hospital stay or course of treatment, the service will be continued without liability to the Member until the Member has been notified of the finding.

If the first notice was not in writing, Anthem will confirm its finding about the expedited review in writing within 2 working days of providing notice of that finding.

Appeals

Level One Appeal Process
You or your authorized representative, if not satisfied with the first decision or the finding on a complaint, may Appeal the decision to the Anthem Appeals Department. An Appeal may be done orally or in writing and must include specific reasons why you or your representative do not agree with the finding. Appeal of a finding must be sent to within one-hundred-eighty (180) calendar days of the date the finding was made, unless there are special circumstances. We have the right to review the reason for the delay and find out whether they warrant acceptance of the Level One Appeal past the 180-day time frame.

On Appeal, the file will be reviewed. Appeals will be reviewed by an appropriate peer or peers who have not been involved with a prior finding. More information may be submitted by or for the Member, any treating physician, or Anthem. A finding will be made within thirty (30) days after we receive the request for an Appeal.

The decision will include:

- The names, titles and information that qualifies the person or persons evaluating the appeal;
- A statement of the reviewers' understanding of the reason for the Covered Person's request for an Appeal;
- The reviewers' finding in clear terms and the reason in enough detail for the Covered Person to respond to the health carrier's finding;
- A reference to the evidence or information used as the basis for the finding, including the clinical review materials used to make the decision. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Anthem in giving its first Adverse Determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.
- The notice must advise of any additional appeal rights, and the process and time limit for exercising those rights. Notice of external review rights must be provided to the Enrollee and a description of the process for sending in a written request for second level grievance review.

When the finding is made, if the Member, or Member representative, does not agree with the finding, they may submit a voluntary second level Appeal to Anthem, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at **1-800-300-5000.**

If you choose to request a voluntary second level Appeal, you may meet with the review panel in person, or at Anthem's expense by conference call, video conferencing or other appropriate technology to present your concerns with our adverse determination.

On a Level Two Appeal, the entire record will be reviewed.

Appeals of a clinical nature will be reviewed by an appropriate peer or peers who have not been involved with the prior finding. Additional information may be sent in by or for the Member, any treating Physician, or Anthem BCBS. You or your representative may meet with the review panel. If you do not request to meet in person, the decision for second level grievance reviews will be made within 30 calendar days. If you do request to appear in person, the review will be done within forty-five (45) days after we receive the Member's Level Two Appeal. A written decision will be sent to the Member within five (5) working days of the review. Once a final decision has been made by the Second Level Appeal panel, the Member may then ask for an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS.

In any Appeal under this procedure in which a professional medical opinion about a health condition is an issue, you may have the right to an independent second opinion, of a provider of the same specialty, paid for by the plan.

Upon the request of a Member, Anthem shall provide to the Member all information that was used for that finding that is not confidential or privileged.
A Member has the right to:

- Attend the second level review;
- State his or her case to the review panel;
- Submit added material both before and at the review meeting;
- Ask questions of any employee in the meeting; and
- Be assisted or represented by a person of his or her choice.

External Review Process

Your representative is a person who has your written consent to represent you in an external review; a person authorized by law to give consent to request an external review for you; or a family member or your treating physician when you are unable to provide consent to request an external review.

If you, or your representative, do not agree with the outcome of the Level One or Voluntary Level Two Appeal on an Adverse Health Care Treatment Decision by Anthem, you may make a written request for external review to the Bureau of Insurance. A health care treatment decision means a decision regarding diagnosis, care, or treatment when medical services are provided by a health plan, and involves issues of medical necessity, preexisting condition findings and findings regarding experimental or investigational services. An adverse health care treatment decision is a decision made by us or on our behalf denying payment. The request must be made within 12 months of the date the Member has received the final adverse health care treatment decision of the Level One or Voluntary Level Two Appeal panel.

You or your representative may not request an external review until you have completed Level One of the internal Appeals process unless:

- Anthem BCBS did not make a decision on an Appeal within the time period required or has failed to follow all the requirements of the appeal process as state and federal law require, or the Member has asked for an expedited external review at the same time as applying for an expedited internal appeal;
- Anthem BCBS and you both agree to bypass the internal Appeals process;
- The life or health of the Member is at risk;
- The Member has died; or

- The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written finding must be made by the independent review organization within thirty (30) days after receipt of a completed request for external review from the Bureau of Insurance.

Expedited External Review. An external review finding must be made as quickly as a Member's medical condition requires but no more than 72 hours after the completed request for external review is received if the 30-day time frame above would risk the life or health of the Member or would put the Member's ability to get back maximum function at risk.

An external review finding is binding on Anthem. You, or your representative, may not file a request for a second external review involving the same adverse health care treatment decision for which you have already received an external review decision.

Legal Action Against Anthem BCBS

No legal action may be brought against Anthem BCBS until the member or the member's authorized representative has exhausted the complaint and appeals process outlined above. Any action must be initiated within three (3) years from the earlier of:

- The date of issuance of the written external review decision; or
- The date of issuance of the underlying adverse Level One Appeal decision or the Level One grievance determination notice.

Section Seven
Definitions

This section explains the meaning of some of the words in Certificate. Other words may be defined in the text.

Accident Care Treatment of an accidental bodily injury sustained by the Member that is the direct cause of the condition for which Benefits are provided and that occurs while the insurance is in force.

Additional Services Coinsurance The percentage you are required to pay toward the cost of some covered Additional Services. The Schedule of Benefits specifies the percentage.

Additional Services Deductible The amount you are required to pay each calendar year toward the Maximum Allowance for certain covered Additional Services before benefits are provided. This amount is listed on your Schedule of Benefits.

Affidavit of Domestic Partnership A statement signed by the subscriber and domestic partner and duly notarized, which attests to shared financial obligations, shared primary residence, and mutual responsibility for the welfare of the subscriber and domestic partner.

Ambulatory Surgical Facility A facility that meets both of the following requirements:

- Licensed as an ambulatory surgery center, or is Medicare certified; and
- Meets our standards for participation.

Amendment An addition, change, correction, or revision to the terms and conditions of this contract.

Annual Coinsurance Limit The limit on the coinsurance you pay each year for Additional Services. After you meet the annual coinsurance limit, you pay no further coinsurance for most Additional Services. Copayments still apply.

Annual Out-of-Pocket Limit The limit on the deductible and coinsurance you pay each year. After you meet the annual out-of-pocket limit, you pay no further deductible or coinsurance for most services.

Annual Review Date The date set by us and your group on which the contract renews each year.

Appeal A request for a review of our initial decision, a decision on a registered complaint, or determination of medical necessity.

Benefits Payments we make on your behalf under this contract.

Calendar Year The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding calendar year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

Certificate The document that specifies the health care benefits available to members under this contract.

Chiropractor A person who is licensed to perform chiropractic services, including manipulation of the spine.

Coinsurance The percentage paid toward the cost of some covered services.

Community Mental Health Center An institution that meets both of the following requirements:
- Licensed as a comprehensive level community mental health center; and
- Meets our standards for participation.

Companion Plan Coinsurance The percentage Anthem Blue Cross and Blue Shield pays toward the cost of some covered Additional Services and the percentage you pay. The Schedule of Benefits specifies these percentages.

Contract This Certificate, any amendments, riders, or attached papers; the Group Agreement; your application; and the Schedule of Benefits.

Contract Holder The employer, association, or trust that applies for and accepts this coverage on behalf of its members.

Copayment A fixed dollar amount required to be paid by each member for certain covered services under this contract. Please refer to your Schedule of Benefits for specific information.

Cosmetic Services Medical/surgical procedures or services intended solely to change or improve appearance or to treat emotional, psychiatric, or psychological conditions.

Covered Service Services, supplies or treatment as described in this Certificate. To be a covered service the service, supply or treatment must be:
a. Medically necessary or otherwise specifically included as a benefit under this Certificate.
b. Within the scope of the license of the professional performing the service.
c. Rendered while coverage under this Certificate is in force.
d. Not experimental or investigational or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto.
e. Authorized in advance by us if such preauthorization is required in this Certificate.

Creditable Coverage (Prior Coverage) Coverage under an individual or group contract or policy that was in effect within 3 months before you were eligible for coverage under this Contract if you apply when initially eligible, or within 3 months of your effective date if you apply as a Late Enrollee. Creditable coverage includes Group or individual health insurance, Medicare, Medicaid, CHAMPUS, Indian Health Care Improvement Act, state health benefit risk pool, federal employees health benefit plan, qualified public health plan, the Peace Corps health benefit plan, S-CHIP, or a qualified foreign health plan. In calculating the period of Creditable Coverage, all periods of coverage under all types of Creditable Coverage are added together unless there is a consecutive 90-day or longer break in the time period the individual has Creditable Coverage.

Custodial Care Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Administering normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas; and
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be custodial whether or not it is recommended or performed by a professional and whether or not it is performed in a facility (e.g. hospital or skilled nursing facility) or at home.

Day Treatment Patient A patient receiving mental health or substance abuse care on an individual or group basis for more than two hours but less than 24 hours per day in either a hospital, rural mental health center, substance abuse treatment facility, or community health center. This type of care is also called partial hospitalization.

Deductible The amount you may be required to pay each year toward the Maximum Allowance for certain covered services before this contract provides benefits.

Dental Service Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth include: the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the lamina dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

Dependent The eligible subscriber's lawful spouse, domestic partner, children up to 26 (including biological children, adopted children or children placed for adoption, the Subscriber's grandchildren provided they are living with the subscriber in a parent-child relationship and are primarily supported by the Subscriber, stepchildren, legally placed foster children who live with the Subscriber or children for which the Subscriber is a legal guardian). Coverage may continue for dependent children beyond age 26 if they are mentally or physically disabled. The disability must have begun before the child's 26th birthday, and the child must have been covered by us on and continuously since his or her 26th birthday.

Please see the "Eligibility, Termination and Continuation of Coverage" section for additional information.

Diagnostic Service A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Discount Favorable rates or discounts we have negotiated with hospitals and other providers. Members benefit from these rates or discounts since they are applied prior to calculating your share of costs. Discounted charges reduce the expenses paid by us which helps to lower the contract costs.

Domestic Partner A person of the same or opposite sex as the subscriber, neither of whom is married to another person, who can demonstrate shared financial obligations, shared primary residence, and shared responsibility for the welfare of the subscriber.

Domiciliary Care 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.

Durable Medical Equipment Equipment that meets all of the following criteria:

- Can withstand repeated use;
- Is used only to serve a medical purpose;
- Is appropriate for use in the patient's home;
- Is not useful in the absence of illness, injury, or disease; and
- Is prescribed by a physician.

Durable medical equipment does not include fixtures installed in your home or installed on your real estate.

Effective Date The first day of coverage with Anthem Blue Cross and Blue Shield.

Emergency Medical Condition A physical or mental condition, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part; or

With respect to a pregnant woman who is having contractions:

- That there is inadequate time to safely transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Service Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the member's physical and/or mental health in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part.

Examples of illnesses or conditions that may require emergency services include, but are not limited to: heart attack, stroke or severe hypertensive reaction, coma, blood or food poisoning, severe bleeding, shock, obstruction (airway, gastrointestinal or urinary tract), and allergic or acute reactions to drugs.

Enrollment Date The first day of coverage or, if there is a waiting period, the first day of the waiting period.

Enrollment Period The period following your initial eligibility for enrollment.

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 BCBS determines to be experimental or investigational.

Anthem BCBS 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.

(a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

(i) 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

(ii) Has been determined by the FDA to be contraindicated for the specific use; or

(iii) 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, unless otherwise required by law; or

(iv) Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

(v) Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by Anthem BCBS. In determining whether a service is experimental or investigational, Anthem BCBS will consider the information described in subsection (c) and assess the following:

(i) Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;

(ii) 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;

(iii) 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; and

(iv) Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information considered or evaluated by Anthem BCBS 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:

(i) Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

(ii) Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

(iii) 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

(iv) Documents of an IRB or other similar body performing substantially the same function; or

(v) Consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vi) The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vii) Medical records; or

(viii) The opinions of consulting providers and other experts in the field.

(d) Anthem BCBS identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational.

Family Planning Agency An agency that meets both of the following requirements:
- Is a delegated family planning agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets our standards for participation.

Freestanding Imaging Center An institution that meets both of the following requirements:
- Licensed (where available) as a freestanding imaging center, freestanding diagnostic center, or freestanding radiology center; and
- Meets our standards for participation.

Freestanding Surgical Facility An institution that meets all of the following requirements:
- Has a medical staff of physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
- Has equipment for emergency care;

- Has a blood supply;
- Maintains medical records;
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis;
- Is licensed in accordance with the law of the appropriate legally authorized agency; and
- Meets our standards for participation.

Grace Period The 31 days that begin with and follow the due date of an unpaid premium charge.

Group The employer, association, or trust that applies for and accepts this coverage on behalf of its members.

Group Companion Plan This Plan that provides coverage in addition to Medicare Part A and B.

Group Companion Plan Lifetime Reserve Days The 365 days of inpatient hospitalization coverage that is available under this Plan once Medicare benefits have been exhausted.

Home Health Agency An institution that meets both of the following requirements:
- Licensed as a home health agency, and
- Meets our standards for participation.

Hospice A facility that meets both of the following requirements:
- Licensed as a hospice; and
- Meets our standards for participation.

Hospice Care Services that furnish pain relief, symptom management, and support to terminally ill patients and their families.

Hospital An institution that is duly licensed by the state of Maine as an acute care, rehabilitation or psychiatric hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Error of Metabolism A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Independent Laboratory An institution that meets both of the following requirements:
- Licensed as an independent medical laboratory; and
- Meets our standards for participation.

Infertility The inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the presence of a demonstrated condition recognized as a cause of infertility by the American College of Obstetrics and Gynecology, the American Urologic Association, or other appropriate independent professional associations.

Inpatient A registered bed patient who occupies a bed in a hospital, skilled nursing facility, or residential treatment facility. A patient who is kept overnight in a hospital solely for observation is not considered a registered inpatient. This is true even though the patient uses a bed. In this case, the patient is considered an outpatient.

Inpatient Stay One period of continuous, inpatient confinement. An inpatient stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care hospital to another acute care hospital as an inpatient when medically necessary is part of the same stay.

Maintenance Prescription Drug A Prescription Drug that is used on a continuing basis for the treatment of a chronic illness, such as heart disease, high blood pressure, arthritis and/or diabetes.

Maintenance Therapy Any treatment, service, or therapy that preserves the member's level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

Maximum Allowance The highest dollar amount we will pay for a covered service based on our contracts with providers. Our payment will be based on the most cost effective services that can be safely administered.

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

Medically Necessary Health Care Health care services or products provided to a member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the member or physician or other health care practitioner.

Medicare The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Medicare Benefit Period A benefit period is a way of measuring your use of inpatient services under Medicare hospital insurance. A benefit period begins the first day you are hospitalized. Medicare helps pay for up to 90 days of medically necessary inpatient hospital care per benefit period, plus an additional 60 days which may be used only once and is called "lifetime reserve days." When you have been out of the hospital or skilled nursing facility for 60 consecutive days, a new benefit period starts the next time you go into a hospital. There is no limit to the number of benefit periods you can have.

Medicare Lifetime Reserve Days If you are hospitalized for more than 90 days in one benefit period, Medicare will help pay for an additional 60 days, called "lifetime reserve days." These reserve days can be used only once.

Medicare Part A (Hospital) Coinsurance The per day amount you owe for the 61st to 90th day of inpatient hospital care in each benefit period.

Medicare Part A (Hospital) Deductible The amount you are required to pay per admission for the 1st to the 60th day of inpatient hospital care in each benefit period.

Medicare Part B (Medical) Coinsurance The percentage you owe toward the cost of Medicare-approved expenses for Part B services.

Medicare Part B (Medical) Deductible The amount you are required to pay for Medicare-approved expenses for Part B services during a calendar year before Medicare benefits begin.

Member The subscriber and all family members who are eligible for coverage and who we accept for coverage under this contract.

Mental Health Service A service to treat any disorder that affects the mind or behavior regardless of origin.

Morbid Obesity A condition of persistent and uncontrolled weight gain existing for a minimum of five consecutive years that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

Network Pharmacy Any Pharmacy, located within the United States, acceptable as a Participating Pharmacy by Anthem to provide Covered Drugs to Member*s* under the terms and conditions of this Certificate**.** Also referred to as "Participating Pharmacy".

Network Providers Health care providers that have a written agreement with Anthem BCBS to furnish health care services under this contract. Also referred to as participating providers.

Network Specialty Pharmacy Any appropriately licensed Pharmacy located within the United States which has entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to render Specialty Drug services and certain administrative functions.

Non-Network Pharmacy Any appropriately licensed Pharmacy, located within the United States that is not a Participating Pharmacy under the terms and conditions of this Certificate. Also referred to as "Non-Participating Pharmacy".

Non-Network Providers Health care providers that do not have a written agreement with Anthem BCBS to furnish health care services under this contract. Also referred to as non-participating providers. Providers who have not contracted or affiliated with our designated Subcontractor(s) for the services they perform under this Plan are also considered non-network providers.

Orthognathic Surgery A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Our See definition of "We, Us, or Our."

Outpatient A patient who receives services at a provider and who is not a registered inpatient or a day treatment patient. A patient who is kept overnight in a hospital solely for observation is considered an outpatient. This is true even though the patient uses a bed.

Pharmacy Any retail establishment operating under a license and in which a registered pharmacist dispenses prescription drugs.

Pharmacy and Therapeutics Committee Anthem's national committee made up of Physicians and other experts in medicine and Pharmacy.

Physician See definition of "Professional."

Pre-existing Condition The existence of a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received from a licensed individual, as defined by the state of Maine, during the six months immediately preceding the enrollment date.

Prescription Drugs A narcotic or medicine approved by the federal Food and Drug Administration (FDA) for use outside of a hospital dispensed under a physician's written order. Prescription drugs are: required by state law to be dispensed only with a prescription; required by law to display the notice, "Caution: Federal law prohibits dispensing without a prescription"; or any other drug we may approve through our drug approval process.

Prostheses Prostheses are appliances that replace all or part of a body organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider A licensed health care institution, facility, agency, or an independently billing, licensed health care specialist acting within the scope of his or her license. Only the following providers are eligible for payment under this contract:

- Acute-care Hospitals
- Skilled Nursing Facilities
- Rural Health Centers
- Home Health Agencies
- Ambulatory Surgery Centers
- Hospices
- Community Mental Health Centers
- Substance Abuse Treatment Facilities
- Licensed Pharmacies
- Acute Care Psychiatric and Rehabilitation Hospitals
- Independent Laboratories
- Freestanding Imaging Centers
- Family Planning Agencies
- Durable Medical Equipment Providers
- Home Infusion Providers

- Other providers that have written contracts with us
- Other providers, as required by law

Physicians
- Doctor of Medicine
- Doctor of Osteopathy

Other Professionals
- Doctor of Optometry
- Doctor of Chiropractic
- Doctor of Podiatry
- Doctor of Dentistry
- Doctor of Psychology
- Licensed Acupuncturist
- Licensed Audiologist
- Licensed Psychiatric Nurse Specialist
- Licensed Clinical Social Worker
- Licensed Clinical Professional Counselor
- Licensed Marriage and Family Therapist
- Licensed Pastoral Counselor
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Registered Nurse
- Licensed Practical Nurse
- Certified Nurse Midwife
- Ambulance Services
- Other professionals that have written participating agreements with us
- Other professionals as required by law

Radiation Therapy The use of high energy penetrating rays to treat an illness or disease.

Reconstructive Procedures Procedures performed on structures of the body to improve or restore bodily function or to correct deformity when there is functional impairment resulting from disease, trauma, previous therapeutic process, or congenital or developmental anomalies.

Rural Health Center An institution that meets both of the following requirements:
- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets our standards for participation.

Sitter/Companion A person who provides short-term supervision of hospice patients during the temporary absence of family members.

Skilled Nursing Facility (SNF) An institution that meets all of the following requirements:
- Licensed as a skilled nursing facility;
- Accredited in whole or in a specific part as a skilled nursing facility for the treatment and care of inpatients;

- Engaged mainly in providing skilled nursing care under the supervision of a physician in addition to providing room and board;
- Provides 24-hour-per-day nursing care by or under the supervision of a registered nurse (RN);
- Maintains a daily medical record for each patient;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets our standards for participation.

Specialist Service A service by a professional practicing in specialty areas such as cardiology, neurology, surgery, and other specialties.

Specialty Drug The term "Specialty Drug" means prescription legend drugs which:
- are approved to treat limited patient populations, indications or conditions;
- are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- have limited availability, special dispensing and delivery requirements, and/or require additional patient support- any or all of which make the Drug difficult to obtain through traditional pharmacies.

Subcontractor An organization or entity that provides particular services in specialized areas of expertise. Examples of subcontractor specialized areas of expertise include, but are not limited to, prescription drugs, mental health/ behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Subscriber The person who applied for coverage under this contract and whose application and payment of required premium charges we have accepted.

Premium Charge The rates established by us as consideration for benefits offered in this contract.

Substance Abuse The misuse, excessive use, or improper use of alcohol or drugs to the extent that such use contributes to physical, mental, or social dysfunction, regardless of origin.

Substance Abuse Treatment Facility A residential or nonresidential institution that meets all of the following requirements:
- Licensed or certified as a substance abuse treatment facility;
- Provides care to one or more patients for alcoholism and/or drug dependency;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets our standards for participation.

Surgical Assistant A physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified professionals as permitted by law and recognized by us who actively assists the operating surgeon in performing a covered surgical service.

Surgical Service A service performed by a professional acting within the scope of his or her license that is:
- A generally accepted operative and cutting procedure;
- An endoscopic examination or other invasive procedure using specialized instruments; or
- The correction of fractures and dislocations.

Telemedicine The use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine, or e-mail.

Terminal Illness A terminal illness exists if a person becomes ill with a prognosis of 12 months or less to live, as diagnosed by a physician.

Tier Listing The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Us See definition of "We, Us, or Our."

Waiting Period The period required by your group or us before enrollment in this group health plan is allowed.

We, Us, or Our Anthem Blue Cross and Blue Shield and its designated affiliates.

You or Your The subscriber and all dependents whom we accept for coverage under this contract.

INDEX