



You've made a good decision in choosing Blue AccessSM

Marietta College

**For more information, visit our web site at anthem.com
07/01/2005 00033832**

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Ten Ways to
get the
Most Value from
your Anthem
membership

Member Handbook



Congratulations on your membership to Anthem Blue Cross and Blue Shield. You are joining more than 88 million people - that's one in every three Americans - who already enjoy the benefits of coverage from a Blue Cross and Blue Shield Plan.

You know that health coverage gives you financial protection against mishaps and illness in the future. So, while you may pay premiums one year without needing major services, you may have a medical situation in the following year. Not many of us can afford to pay typical billed charges of \$2,000 for a MRI of the brain, \$5,000 for a normal delivery of a baby, or more than \$50,000 for a coronary bypass.

At Anthem, we're here to help protect you against such financial hardships. But we also want to give you something more - benefits you can use. That's why we've listed the top 10 things you can do to make sure you get the most value from your Anthem membership.

Ten ways to get the most Value from Your Anthem Membership.

1 Visit anthem.com and make your life a little easier

With work, meetings, kids, appointments and errands, who has time to find a doctor or check a claim? Now, you can do these things at your convenience with **anthem.com**. Visit the web site to:

- search the provider directory
- check for a medication on the Anthem formulary.

You can even manage your benefits online. Simply register and log on to myanthemTM.*

- order a new ID card.
- request an address change.
- view your benefits and copayments.
- check a claim status.
- update coordination of benefits information.
- access myanthem/misalud in Spanish.

AHP-0983 (3/04)

2 Keep your ID card with you

Be sure to carry your Anthem ID card with you at all times. You will probably need to show it every time you visit a physician's office, hospital, urgent care facility, pharmacy or any other health care provider. Additionally, your Anthem ID card is a handy resource for copayment amounts and telephone numbers.

Your ID includes:

Member information

Your name and identification number

Primary care physician information

Shows if you are required to have a primary care physician (PCP). If your plan does not require a PCP, "Not required" will appear

Begin date

The date your coverage begins.

Name MEMBER NAME	Product Name
Identification no. XXX123456789	Network/PCP co-pays
Group No. 123456789	Office Visit \$00
Plan No. 123	Emergency Room \$00
Primary Care Physician xxxxxxxxxxxxxx	Urgent Care \$00
Begin date: 01/01/2000	RX Deductible \$00
	RX Formulary \$00/\$00
	RX Non-Formulary \$00/\$00
	Inpatient \$00
	Outpatient \$00
	Mental Hlth Office Visit \$00

Copayments

A partial list of your copayments. See your Health Certificate for a complete list.

Mailing address

Address to send claims.

Mail claims to: 1234 Anywhere Ave. Anywhere, KY 45241-2447	Precert Med/Surgical Services: 800-xxx-xxxx xxx-xxxx
Member Services: k-xxx-xxxx (Local) k-xxx-xxxx (Nationwide)	Provider Inquiry: xxx-xxx-xxxx (Local) 800-xxx-xxxx (Nationwide)
Out of Coverage While Traveling: k-xxx-xxxx	Dental: 800-xxx-xxxx
Mental Health Services: k-xxx-xxxx	Vision: xxx-xxx-xxxx
	Pharmacy Provider Services: 800-xxx-xxxx

Phone number

Phone numbers to answer questions about

3 Take your health coverage on the road

As an Anthem member, you can use your benefits from coast to coast. All of our plans include **Coverage While Traveling**, no matter where or why you're traveling. You can rest assured that whether you need emergency care, urgent care, or follow-up care, your benefits will cover you.

1. For care, always contact your PCP or network provider for advice about appropriate treatment, then call the toll-free Coverage While Traveling number or the member service number on your ID card to be referred to a participating physician or hospital. Benefits may vary by design.
2. Contact your PCP or network provider within 24 hours (48 hours if you are an Indiana member) or as soon as reasonably possible to coordinate follow-up care. Benefits may vary by design.
3. Obtain and save receipts for any medical treatment you receive so you can file a claim for covered services when you return home.

If you have a suitcase icon on your ID card (as illustrated on the ID card on the previous page), you're covered through the **BlueCard[®] program**, which links Anthem networks with other Blue Cross and Blue Shield networks. This gives you access to more than 85 percent of hospitals and nearly 90 percent of physicians in the country.²

To use the BlueCard program:

1. Find a physician, hospital, or other health care provider (Go to **anthem.com**, call BlueCard Access at **(800) 810-BLUE** or call the Anthem Member Services number on your ID card.)
2. Call Anthem to verify coverage and receive prior approval for certain elective inpatient and outpatient services.
3. Present your Anthem ID card at your visit.
4. Don't hassle with paperwork - the physician, hospital or health care provider will file your claim.
5. Receive your Anthem Blue Cross and Blue Shield Explanation of Benefit statement in the mail.

Of course, in the case of an emergency, call 911 or seek immediate care with the nearest doctor or hospital.

4 Take responsibility for knowing your benefits

Anthem continually strives to help ensure that you and your family have access to the quality health care you deserve. But you have a role to play as well. Anthem encourages you to exercise your rights and make sure you meet your responsibilities. There is a complete list of your rights and responsibilities in your certificate, benefit booklet, or online at anthem.com.

Anthem has a contract to provide the benefits as they are outlined in your certificate or benefit booklet. Read this document carefully and refer to it before receiving any services. It's your legal contract. Here are a couple of areas to pay particular attention to:

Network and Non-network Providers

On your behalf, Anthem contracts with doctors, clinics, hospitals and other medical providers to supply care for you. Certain plans allow you to only use these Network providers, while other plans allow you to use Non Network providers, or providers that don't contract with us. If you use a Non Network provider, you pay more out of pocket. So, for maximum savings, use Network providers. **Since networks change throughout the year, make sure your provider is in Anthem's network when you make your appointment.**

If you are a Blue Traditional member, your plan does not have a Network. Members may receive care from any hospital or physician. However, those hospitals and physicians that participate in Anthem's networks will normally submit claims on behalf of members. When a Blue Traditional member seeks care from a non-contracted provider, the member is responsible for submitting his or her own claims.

Important Days to Remember

Birthdays, new babies, adoptions, moving and changes in marital status can keep you busy. But take some time to make sure your coverage keeps up with your life. **You typically have 31 days within an event to make changes to your coverage, including adding or removing dependents from your plan.** If you have dependent children turning 19, check your plan to see if they are covered beyond this age. And if you move, please remember to update your address by calling Member Services, or visiting anthem.com.

Pre-authorization

Some services require preauthorization. What this means is you or your doctor must call Anthem before you receive certain services to ensure you get maximum coverage. This process can help you avoid unnecessary out-of-pocket costs later.

Exclusions

Some health benefits are not covered in the plan selected. These are called exclusions and are listed in a special section of your certificate or benefit booklet. **Keep in mind that while a physician may advise that a certain service is medically necessary, the benefits plan selected may not cover it. The service must be within the scope of your benefits to be covered.**

The easiest way to take charge of your benefits is to read your certificate or benefit booklet!

5 Be familiar with your financial responsibilities

Depending on your specific plan, you may have to pay for the following:

Premium

This is a monthly payment to Anthem. If you have group coverage, chances are you and your employer share in the responsibility of paying the premium. This amount is usually deducted from your paycheck.

Copayment

This is your share of the cost for a particular health care service. A copayment can be a flat dollar amount and/or a percentage of the maximum allowable amount. It is generally due at the time you receive a medical service. Copayments may or may not apply to your deductible or out-of-pocket maximum. Check your certificate to see how your plan operates.

Deductible

This is the amount you must pay each year before the health plan begins to pay.

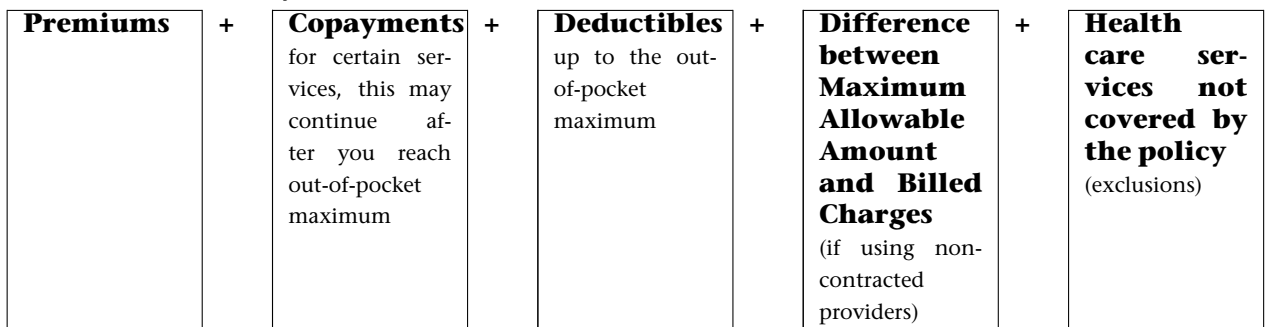
Difference between Maximum Allowable Amount and Billed Charges

The Maximum Allowable Amount is Anthem's negotiated rate with network or participating providers. Anthem also pays this rate to providers that don't have a contract with us. When you use a non-contracted provider, you may be responsible for paying the difference between the Maximum Allowable Amount and the provider's standard billed charge.

Out-of-pocket Maximum

This dollar amount is the maximum amount you will pay for covered benefits each benefit period (usually 12 months). Some copayments may still apply.

You'll need to check your certificate for your specific coverage; but basically, your health care costs for a year include:



6 Get more from your prescription drug coverage

The cost of prescription drugs continues to increase. Use your prescription benefits wisely, and you may be able to better manage these costs while getting the prescriptions you need.

Use the Anthem formulary/drug list

The Anthem formulary/drug list is a list of prescription drugs that have been approved for their safety, quality and cost effectiveness. When your doctor prescribes a medication from this list, you'll pay a smaller copayment. In general, a generic medication on the Anthem formulary/drug list will have the most affordable copayment. A brand-name medication on the list will have a larger copayment. Drugs not included on the Anthem formulary/drug list will cost the most.

For a copy of the Anthem formulary/drug list:

- visit **anthem.com** and select pharmacy services
- call the member services number on your ID card
- for a recording of recent updates to the formulary/drug list, call **(877) 468-5279**, TDD users should call **(800) 221-6915**

Choose generics

Generic medications can cost less and are just as effective as their brand-name counterparts. Generics contain the same active ingredients and they meet the Food and Drug Administration (FDA) specifications for stability, strength, quality and purity. Since generics use the same active ingredients your body will absorb and use the generic medication in the same way as a brand-name drug. Talk to your physician or pharmacist about generic medications and if they are appropriate for you.

Save a trip to the pharmacy

With Anthem Rx Direct mail service, you can skip the trip to the pharmacy and have your maintenance medications delivered to your doorstep. It's convenient and could save you money.

- Have your maintenance medication or supplement - such as drugs that treat diabetes, high blood pressure and asthma or prenatal vitamins - delivered to your home, office or anywhere in the country.
- Ask your doctor to prescribe the maximum allowable days supply. You won't have to refill your prescription as much, which means fewer hassles and fewer copayments.
- Refill your orders by mail, phone or Internet.

It's easy to get started. Visit **anthem.com** for instructions, an application form and the Anthem Rx mailing address. You can also call **(888) 613-6091**, Monday through Friday, 8:30 a.m. to 5 p.m., Eastern Time. A customer care professional will guide you through the process. Have your prescription form or container and a credit card (for copayment) close by for easy reference.

7 Take an active role in your health care

Taking an active role in your health care will help you make the best decisions for your health and your budget. Here are several things you can do to become a savvy health care consumer:

Know your family doctor (and make sure your doctor knows you)

Your doctor is your most important partner in health care. Establishing a long-term relationship with a doctor can help you feel more comfortable asking questions and sharing personal health information. When you build a relationship with a doctor in Anthem's network, you'll make the best use of your benefits, which can help you save money. Some Anthem plans require you to select a primary care physician (PCP). If your card indicates that this is necessary and you have not selected a physician, please call Member Services. Please note that this is to only encourage you to build a relationship with a physician, it does not mean that you are required to get a referral.

Ask for a second opinion

You may want to seek a second opinion before receiving a certain service. A second opinion may help ensure that you are getting the most appropriate treatment for your health issue.

Check bills

Physicians, hospitals, or other health care providers may send you a bill for a service your Anthem health plan covers. This is often normal procedure. But, if you aren't aware of it, you may end up paying for a service that Anthem has already paid for. **Before paying any bill, you may want to wait for your Anthem Explanation of Benefits (EOB) statement to come in the mail. This statement will detail what Anthem covers and what amount you owe (if any) to the doctor, hospital, or other health care provider.** However, if you are a member of a Blue Traditional[®] plan, you may have to pay for services up-front. You may also have to submit the claim to Anthem for payment.

Use your preventive benefits

Preventive care can help you avoid an illness before it occurs or diagnose an illness in its early stages. Depending on your specific plan, your preventive benefits may include well visits, health screenings and immunizations. You may also receive helpful reminders for immunizations and age-specific health screenings, as well as other useful health information.

Manage chronic conditions

If you have a condition such as diabetes or asthma, you understand how important it is to manage your health. Successfully managing these conditions can help keep you healthy. Depending on the specific plan, Anthem offers disease management programs that can help you better control:

- asthma and pulmonary disease
- cardiac disease

- chronic kidney disease
- diabetes
- maternity, including high-risk

Enrollees in these programs receive educational materials, reminders, and encouragement on managing their conditions. Additionally, Anthem provides their doctors with guidelines from national independent agencies.

To enroll in one of these disease management programs, visit **anthem.com**, e-mail healthysolutions@anthem.com or call **(800) 480-WELL (9355)**.

Recommended Child, Adolescent and Adult Periodic Health Exams and Screenings

ROUTINE PHYSICALS AND RECOMMENDED SCHEDULE

Ages 0-18 Months- includes height, weight, head circumference, physical exam, counseling
Recommended Schedule* At Birth, 1, 2,4,6,9,12,15,18 months

Ages 2-18 Years- includes height, weight, blood pressure (starting at age 3), physical exam, counseling
Recommended Schedule* Annually ages 2-5 and 11-18; every 2 years ages 6-10

Ages 19-39 Years- includes height, weight, counseling
Recommended Schedule* Every 3-5 years

Ages 40- 64 Years- includes height, weight, counseling
Recommended Schedule* Every 1-2 years

Ages 65+ Years- includes height, weight, counseling
Recommended Schedule* Annually

SCREENINGS AND RECOMMENDED SCHEDULE*

Blood Pressure. Age 18 and older as part of routine preventive care.

Lead. A history of possible lead exposure should be assessed periodically between 6 months and 6 years of age using community specific risk. Physicians should screen children at risk.

Blood Test for Anemia. Once between 6-12 months

Vision. Once in children younger than age 5 years to detect amblyopia and strabismus, and defects in visual acuity. Screening for diminished visual acuity with Snellen visual acuity chart is recommended for elderly persons.

Newborn Hearing. Newborn

Hearing. Frequency varies with patient characteristics

Cholesterol screening should occur every five years starting at age 35 for men and age 45 for women.

Colorectal Cancer screening should begin at age 50 for men and women who are at average risk for colorectal cancer. Options include one or a combination of the following: 1. Annual home fecal occult blood testing (FOBT), 2. Sigmoidoscopy every 5 years, 3. Colonoscopy every 10 years, 4. Double contrast barium enema every 5 years

Pap Smear (women only) Screening should begin within 3 years of onset of sexual activity or age 21 (whichever comes first). Screening should be obtained at least every 3 years.

Chlamydia (women only) screening should be done annually for sexually active women under age 25. Discuss with your doctor about the need for regular screening depending on risk factors.

Mammogram (women only) screening should occur every 1-2 years, with or without clinical breast examination, among women aged 40 and older.

Osteoporosis Screening (women only). Women 65 years of age and older should be screened routinely for osteoporosis. Routine screening should begin at age 60 years of age for women at increased risk for osteoporotic fractures.

Prostate Cancer (men only) should begin annually at age 50, discuss benefits and possible harms of prostate cancer screening

Tobacco cessation, drug and alcohol use, STD's and HIV, nutrition, physical activity, sun exposure, oral health, injury prevention and polypharmacy counseling should be part of all routine preventive care

***The frequency required might vary with patient characteristics. The frequency for high-risk patients is not included in these guidelines.**

U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 3rd Edition, Baltimore: Williams and Watkins.

(Accessed 2/14/2005 at <http://www.ahrq.gov>).

American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Pediatrics, Vol.105, No.3

Mar 2000. pp.645-646.

American Academy of Family Physicians. Summary of policy recommendations for periodic health examinations. American Academy of Family Physicians; Aug 2004.

(Accessed 2/21/2005 at aafp.org).

Health Care Financing Administration. Title I-Medicare Beneficiary Improvements. HCFA Legislative Summary, March 2001.

(Accessed 12/12/2001 at <http://www.hcfa.gov/regs/sum-title1.htm>).

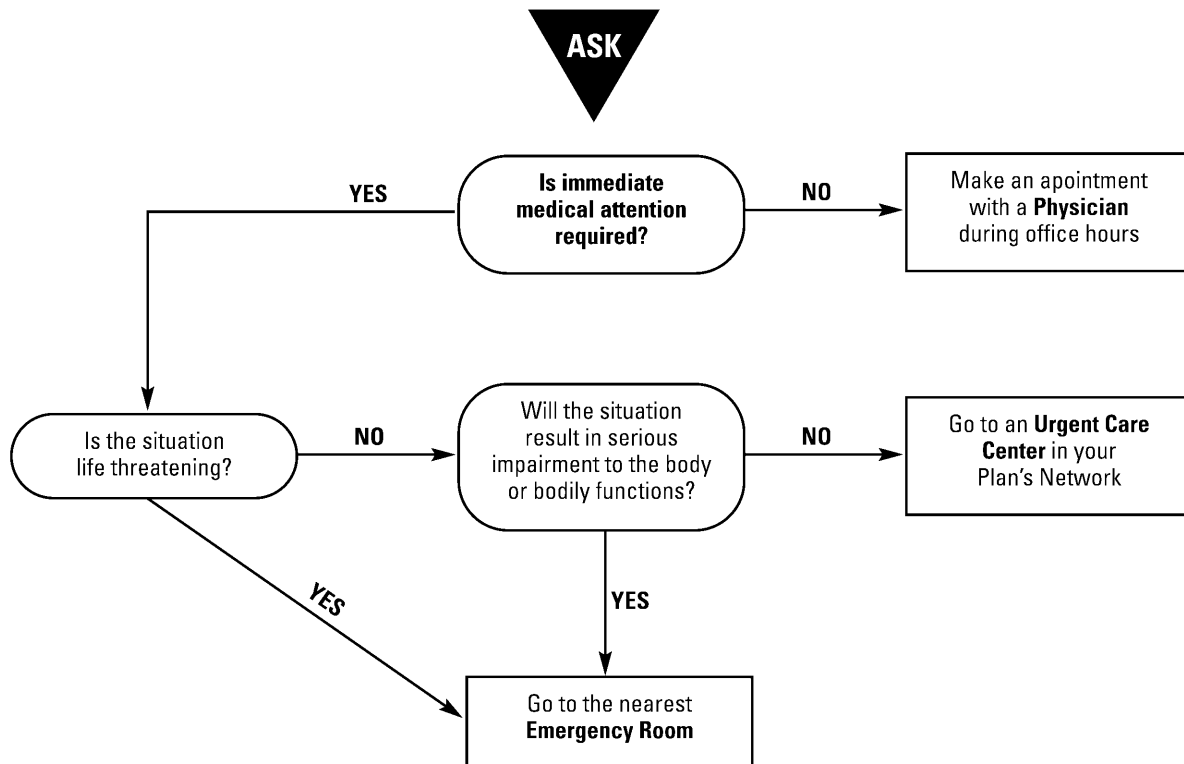
8 Know what to do in an emergency

There's a difference between emergency and urgent care. Be familiar with these differences to ensure that you get the most suitable care. Of course, if you're not sure, call 911 immediately.

Emergency care - Emergencies are medical conditions that in the absence of immediate medical attention could reasonably be expected by the average person to place a person's health in serious danger. Emergencies are usually sudden with severe symptoms. During an emergency, immediately call 911 or go to an emergency room. To ensure the best coordination of care and claims processing, contact Anthem within 24 hours (within 48 hours in Indiana) or as soon as reasonably possible.

Urgent and after-hours care - Urgent care situations are serious conditions that cannot reasonably be postponed for regularly scheduled care, but are not emergencies. In these cases, always call your physician first for advice about the appropriate treatment. Some physicians have extended hours to accommodate patients during evenings and weekends. When choosing a physician, be sure your doctor's hours fit your schedule.

Should I use the Emergency Room, Urgent Care, or call my Physician?



9 Save money and learn more

The more you know the smarter health care choices you can make. Anthem provides information and incentives that will help you live better.

Save money with SpecialOffers@Anthem

Just for being an Anthem member, you have access to special discounts on many health-related products and services. Just find the **SpecialOffers@Anthem** section on **anthem.com** and start saving on:

- eyeglasses, contacts and Lasik eye surgery
- weight loss and weight maintenance programs
- teeth whitening and dental veneers
- health club memberships and fitness equipment
- products to help smokers kick the habit
- health and wellness books
- hearing aids
- massage therapy, vitamins and herbs
- elder care giving

If you don't have Internet access, call **(800) 335-7245**.

Learn more at MyHealth@AnthemSM

Whether you need information about adult acne or want to calculate your ideal weight, **MyHealth@Anthem** is your source for health-related information. Go to **anthem.com** and click on **MyHealth@Anthem** to find:

- daily health news
- a medical library with more than 20,000 articles
- weight loss calculators, health assessments and disease specific Self-Care Centers
- registration for a personalized newsletter that focuses on special conditions - diabetes, asthma or pregnancy
- Subimo's, Healthcare and and Pharma advisorTM, decision support tools

10 Count on Anthem to be there for you

Anthem is here to serve you. That's why customer service is such a high priority. If you have a question, please call the Customer or Member Service number on your ID card. Or, go to **anthem.com** and ask your question online. Customer service representatives are trained to help answer your questions about:

- your coverage and benefit levels
- specific claims for services you have received
- network doctors, specialists and hospitals
- services covered under your plan

For self-directed service, you can sign onto Member Self-Service at **anthem.com**.

For urgent behavioral health and substance abuse assistance, call behavioral health services at the number listed on your ID card. You will be able to speak confidentially to a clinical care manager, 24 hours a day, seven days a week. For non-urgent behavioral health matters or if a behavioral health number does not appear on your ID card, contact customer service at the number listed on your ID Card during normal business hours, Monday through Friday.

¹ Blue Cross and Blue Shield Licensees' Report, July 1, 2003.

² Blue Cross and Blue Shield Association, www.bcbs.com/whoware/history.html, June 16, 2003.



Underwritten by Community Insurance Company

Your Health Certificate

Health Certificate of Coverage

(herein called the "Certificate")

Blue Access

Community Insurance Company

1351 Wm Howard Taft

Cincinnati, OH 45206

1 CERTIFICATE

You have chosen to enroll in Community Insurance Company's product line, Blue Access, to provide you and your family with health care benefits. It is offered through Community Insurance Company dba Anthem Blue Cross and Blue Shield.

Welcome to Anthem Blue Cross and Blue Shield! This Certificate has been prepared to help explain your coverage. Please refer to this Certificate whenever you require medical services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services are provided by Us.

This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. The Certificate also contains Exclusions.

This Certificate supersedes and replaces any Certificate previously issued to you under the provisions of the Group Contract.

Read your Certificate Carefully. The Certificate sets forth many of the rights and obligations between you and the Plan. Payment of benefits is subject to the provisions, limitations, and Exclusions of your Certificate. It is therefore important that you read your Certificate.

Kevin R. Fallon

Notice: If you or your family members are covered by more than one plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific providers and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

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2 MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You Have the Right to:

- Receive information regarding rules and regulations of your health care benefits;
- Be treated respectfully and with consideration;
- Receive all the benefits to which you are entitled under your Certificate and Schedule of Benefits;
- Obtain from a Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through Providers in a timely manner and in a medically appropriate setting;
- Have a candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage;
- Participate with your Physician in decision making about your health care treatment;
- Refuse treatment and be informed by your Physician of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express to Us concerns and complaints about the care and services provided by Physicians and other Providers and to have Us investigate and take appropriate action;
- File a complaint with Us, to appeal that decision as outlined in the Complaint Procedure section of this Certificate and to appeal a decision to the Department of Insurance without fear of reprisal; and
- Confidentiality and privacy.

As a Member, You Have the Responsibility to:

- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-physician relationship;
- Provide complete and honest information about your health care status;
- Follow the treatment plan recommended by the Providers responsible for your care;
- Understand how to access care in routine, emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Copayments, etc.;
- Notify the Provider or Us about concerns you have regarding the services or medical care you receive;
- Be considerate of the rights of other Members, Providers and Our staff;
- Read and understand your Certificate and Schedule of Benefits; and
- Provide accurate and complete information to Us about other health care coverage and/or insurance benefits you may carry.

3 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Copayments and other limits when you receive Covered Services from a Provider. Please refer to the Covered Services section of this Certificate for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, Exclusions, limitations, terms and provisions of this Certificate including any attachments or riders. **This Schedule of Benefits lists the Member’s responsibility for Covered Services.** Benefits for Covered Services are based on the Maximum Allowable Amount. When you utilize a Non-Network Provider you are responsible for any balance due between the Non-Network Provider’s charge and the Maximum Allowable Amount in addition to any Copayments, Deductibles, and non-covered charges.

BENEFIT PERIOD	Calendar Year
Dependent Age Limit	To the end of the calendar year in which the child attains age 19; or to the end of the calendar year during which the child attains age 24 if the child qualifies as a Federal tax exemption.
Pre-Existing Period	Services, supplies or other care incurred for any Pre-Existing Conditions in existence 6 Months prior to your Enrollment Date are not covered for 12 Months after your Enrollment Date.

Deductible	Network	Non-Network
Per Person	\$1,000	\$2,000
Per Family	\$2,000	\$4,000

Note: Any amounts applied to the Deductible for expenses incurred during the last three months of the Benefit Period will also be applied to meet the next Benefit Period’s Deductible, but not the Out-of-Pocket.

Out-of-Pocket Limit	Network	Non-Network
Per Person	\$4,000	\$8,000
Per Family	\$8,000	\$16,000

Note: The Out-of-Pocket Limit includes all Deductibles and/or percentage Copayments you incur in a Benefit Period except for the following services:

- Prescription Drug Benefits
- Human Organ and Tissue Transplant Services

The Out-of-Pocket Limit also includes Copayments for the following services when listed as dollar amounts:

- Physician Office Services (even if for Mental Health Conditions)
- Preventive Care Services
- Emergency Room Services

- Urgent Care Services

Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Copayments will be required for the Member and/or family for the remainder of the Benefit Period, except for the services listed above.

Network and Non-Network Deductibles, Copayments, and Out-of-Pocket Limits **are separate and do not accumulate toward each other.** The Deductible(s) apply only to Covered Services with a percentage Copayment, excluding Prescription Drugs and allergy testing when received as a Network service. Prescription Drugs are subject to separate Copayments.

Lifetime Maximum for All Covered Services except Human Organ and Tissue Transplants \$5,000,000 Network and Non-Network Combined

Lifetime Maximum for Human Organ and Tissue Transplants \$1,000,000 Network and Non-Network Combined

Covered Services	Copayments/Maximums	
	Network	Non-Network
Preventive Care	\$25 Copayment per visit	50% Copayment
Physician Office Services	\$25 Copayment per visit	50% Copayment

Note: When the only charge from a Physician office visit is for allergy injections, allergy serum, Diagnostic Services or Other Therapy Services, then any Copayments listed in dollar amounts are waived. Percentage Copayments are not waived.

Allergy Testing	20% Copayment	50% Copayment
Maximum Visits per Benefit Period for:		
Physical Therapy	30 visits when rendered as Physician Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, the Home Care Services limits apply.	
Occupational Therapy	30 visits when rendered as Physician Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, the Home Care Services limits apply.	
Speech Therapy	20 visits when rendered as Physician Office Services or Outpatient Services, combined Network and Non-Network	
Spinal Manipulations	12 visits, combined Network and Non-Network	
Inpatient Services	20% Copayment	50% Copayment
Maximum days per Benefit Period for Physical Medicine and Rehabilitation	60 days (Combined Network and Non-Network)	
Maximum days per Benefit Period for Skilled Nursing Care Facility Services	180 days (Combined Network and Non-Network)	

Outpatient Services

(Hospital/Alternative Care Facility)

Outpatient Surgery

Professional Charges

20% Copayment

20% Copayment

50% Copayment

50% Copayment

Other Outpatient Services

Professional Charges

20% Copayment

20% Copayment

50% Copayment

50% Copayment

Maximum Visits per Benefit Period for Physical, Occupational, Speech, and Spinal Manipulations:

For Benefit Period Maximums, refer to the maximums under Physician Office Services in this Schedule of Benefits.

Diagnostic Services

When rendered as Physician Office Services or Outpatient Services the Copayment is based on the setting where Covered Services are received. Other Diagnostic Services and or tests, including services received at an independent lab, may not require a Copayment.

Emergency Room Services

(If admitted directly from the Emergency Room, the Emergency Room Copayment for that visit is waived.)

\$75 Copayment per visit

\$75 Copayment per visit

Urgent Care Center Services

\$35 Copayment per visit

\$35 Copayment per visit

Ambulance Services

20% Copayment

20% Copayment

Mental Health & Substance Abuse Services

Lifetime Maximum	Inpatient and Outpatient Substance Abuse rehabilitation programs 2 per lifetime	
Inpatient Services	20% Copayment	Mental Health 50% Copayment Substance Abuse 50% Copayment
Outpatient Services Physician Office Services	20% Copayment \$25 Copayment per visit	50% Copayment 50% Copayment

Benefit Period Maximums:

Inpatient Mental Health Services	30 days Network and Non-Network Combined also includes Network Substance Abuse	
Inpatient Substance Abuse Services	30 days includes Mental Health Services	\$550 combined maximum for Inpatient and Outpatient services
Outpatient Substance Abuse Services	50 visits includes Mental Health	\$550 combined maximum for Inpatient and Outpatient services
Outpatient Mental Health Services	50 visits includes Substance Abuse	10 visits per Benefit Period
Home Care Services Maximum Visits per Benefit Period-includes Physical Therapy and Occupational Therapy rendered in the home.	20% Copayment Unlimited	50% Copayment 30 visits per Benefit Period
Hospice Services	20% Copayment	20% Copayment

Human Organ and Tissue Transplant Services

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Covered Transplant Benefit Period

Total of 365 continuous days beginning 1 day immediately prior to a Covered Transplant Procedure.

Transplant Maximum

Lifetime Maximum per Member for all Covered Transplant Services, services combined under this Certificate or any preceding or successive Human Organ and Tissue Transplant Benefit between the Group or Member and the Plan.

\$1,000,000 Network and Non-Network Transplant Provider

Note: Transportation/Lodging/Meals, Procurement, and Hospital Confinement are included in and accrue toward this Lifetime Maximum for all Transplant Services.

Transplants at a Non-Network Facility do not count towards the Out-of-Pocket Maximum.

Non-Network Transplant Facility

Transplant Services provided through a Non-Network Transplant Facility, with respect to the type of Covered Transplant Procedure performed: If the Covered Transplant Procedure is performed in a Non-Network Transplant Facility, you will pay the lesser of 50% Copayment of the billed charges, or 50% Copayment of the Maximum Allowable Amount shown below for the actual Covered Transplant Procedure. This amount will accrue to the \$1,000,000 Lifetime Maximum.

Transplant Services and Procedures	Network Transplant Facility	Non-Network Transplant Facility
<p>With respect to the type of Covered Transplant Procedure performed amount</p>	<p>No Copayment up to the Maximum Allowable Amount</p>	<p>The lesser of 50% Copayment of billed charges or 50% Copayment of the Maximum Allowable Amount shown in the schedule below. If the Provider is also a Network Provider for this Certificate (for services other than Transplant Services and Procedures), then you will not be responsible for Covered Services which exceed our Maximum Allowable Amount. If the Provider is a Non-Network Provider for this Certificate, you will be responsible for Covered Services which exceed our Maximum Allowable Amount.</p>

Adult Procedures

(Includes organ /tissue acquisition)

	Charge Maximum
Adult Heart	\$68,800
Adult Lung	\$97,000
Adult Heart/Lung	\$133,600
Adult Liver	\$97,600
Adult Pancreas	\$75,200
Kidney/Pancreas	\$75,200
Adult Autologous Bone Marrow including High Dose Chemotherapy	\$56,000
Adult Related allogeneic Bone Marrow including High Dose Chemotherapy	\$80,000
Adult Unrelated allogeneic Bone Marrow including High Dose Chemotherapy	\$88,000

Pediatric Procedures (Includes organ/tissue acquisition)	Charge Maximum
Pediatric Autologous Bone Marrow including High Dose Chemotherapy	\$66,400
Pediatric Related Allogeneic Bone Marrow including High Dose Chemotherapy	\$93,600
Pediatric Unrelated Allogeneic Bone Marrow including High Dose Chemotherapy	\$115,200
Pediatric Liver	\$106,400
Pediatric Heart	\$104,000

Transportation Lodging and Meals	Network Transplant Facility	Non-Network Transplant Facility
	No Copayment up to the Maximum Allowable Amount	50% of Maximum Allowable Amount
Medical Supplies, Durable Medical Equipment and Appliances	20% Copayment	50% Copayment

Note: Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.

Physician office Copayments are applied rather than the Network Copayment listed above if medical supplies, Durable Medical Equipment or appliances are obtained in a Network Physician's office.

Maternity Services	20% Copayment	50% Copayment
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Note: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity admission. That admission will be considered a separate Inpatient Service.

Prescription Drugs

Days Supply: Days supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines:

Retail Pharmacy (Network and Non-Network)	30 day supply
Mail Service	90 day supply

Network Retail Pharmacy Prescription Drug Copayment:

Generic Formulary Drugs	\$12 Copayment per Prescription Order
Brand name Formulary Drugs	\$24 Copayment per Prescription Order
Generic or Brand name non-Formulary Drugs	\$40 Copayment per Prescription Order

Anthem's Mail Service Program Prescription Drug Copayment:

Generic Formulary Drugs	\$24 Copayment per Prescription Order
Brand Name Formulary Drugs	\$48 Copayment per Prescription Order
Generic and Brand Name Non-Formulary Drugs	\$80 Copayment per Prescription Order

Non-Network Retail Pharmacy Prescription Drug Copayment: 50% Copayment

Note: Diabetic and asthmatic supplies are covered in full when obtained from a Network Pharmacy. These supplies are covered as Medical Supplies, Durable Medical Equipment, and Appliances if obtained from a Non-Network Pharmacy.

4 DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Actively At Work - Present and capable of carrying out the normal assigned job duties of the Group. Subscribers who are absent from work due to a health related disability, maternity leave or regularly scheduled vacation will be considered Actively At Work.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance by Us to be paid at the Network level.

Benefit Period - The period of time that We pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum - The maximum We will pay for specific Covered Services during a Benefit Period.

Brand Name Drugs - The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to

manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical (Generic) name.

Certificate - This summary of the terms of your benefits. It is attached to and is a part of the Group Contract and it is subject to the terms of the Group Contract.

Copayment - A specific dollar amount or percentage of Maximum Allowable Amounts for Covered Services indicated in the Schedule of Benefits for which you are responsible.

Covered Services - Services, supplies or treatment as described in this Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto;

- Authorized in advance by Us if such Prior Authorization is required in this Certificate.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblastic therapy.

Covered Transplant Services - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage - Prior coverage from a Group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, individual insurance policy, Peace Corps service, U.S. Government plans, or foreign health plans. Prior coverage does not count as Creditable Coverage if there was a break in coverage of 63 days or more prior to applying for this coverage.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, 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;
- 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.

Deductible - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before We start to pay for Covered Services each Benefit Period.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Certificate as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition or a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

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.

Effective Date - The date when your coverage begins under this Certificate. You must be Actively At Work on your Effective Date. Your Effective Date will be the date you become Actively At Work. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber.

Eligible Person - A person who satisfies the Group's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency - An accidental traumatic bodily injury or other medical condition that manifests

itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- Place an individual's health in serious jeopardy;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Enrollment Date - The first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

Experimental/Investigative - Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative. We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

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

- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed

Experimental/Investigative based on the criteria above may still be deemed

Experimental/Investigative by Us. In determining whether a service is Experimental/Investigative, We will consider the information described below and assess whether:

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

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

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

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Federally Eligible Individual - an individual who:

- must have at least 18 months of Creditable Coverage without a significant break in coverage. A significant break in coverage is 63 days without any Creditable Coverage;
- must have been under a group health plan as the most recent coverage;
- cannot be eligible for Medicare/Medicaid;
- cannot be covered under any other health insurance; and,
- has both elected and exhausted any continuation coverage available under Consolidated Omnibus Budget Reconciliation Act (COBRA) or under any similar state program for continuation.

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

Generic Drugs - Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicate those of a Brand Name Drug and is its bioequivalent. Generic Drugs must meet the same FDA specifications for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug.

Group - The employer or other entity that has entered into a Group Contract with the Plan.

Group Contract (or Contract) - The contract between the Plan and the Group. It includes this Certificate, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

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

Inpatient - A Member who receives care as a registered bed patient in a Hospital or other

Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Late Enrollee - An individual whose enrollment under the Plan is a Late Enrollment.

Late Enrollment - Enrollment other than on:

- The earliest date on which coverage can become effective under this Certificate; or
- The date of an event that qualifies for Special Enrollment.

Lifetime Maximum - The maximum dollar amount We will pay for Covered Services during your lifetime.

Mail Service - A Prescription Drug program which offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with the Subcontractor and/or the Plan, and sent directly to the Member's home.

Maximum Allowable Amount - The amount that We, or Our Subcontractor determine is the maximum amount payable for Covered Services you receive, up to but not to exceed charges actually billed. Generally, to determine the Maximum Allowable Amount for a Covered Service, We or Our Subcontractor use internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if

the Provider has a participation agreement with Us for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

For a Non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under this product or any other product. In the absence of a negotiated amount, We shall have discretionary authority to establish as We deem appropriate, the Maximum Allowable Amount for a Non-Network Provider facility. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount as determined by Us after consideration of industry cost, reimbursement, utilization data and other factors We deem appropriate. It is your obligation to pay any Copayments and Deductibles, and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with Us.

Medically Necessary or Medical Necessity - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of

hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);

- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider;
- Not otherwise subject to an exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member - A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your."

Mental Health Conditions (including Substance Abuse) - A condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the chapter titled "Mental Disorders".

- Mental Health is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.
- Substance Abuse is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental

Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions for the Network associated with this Certificate.

Network Transplant Facility - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions for the Network associated with this Certificate. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- Already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- Newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider - A Provider who has not entered into a contractual agreement with Us for the Network associated with this Certificate. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Certificate are also considered Non-Network Providers.

Non-Network Transplant Facility - Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a Benefit Period as listed in the Schedule of Benefits. Such expense does not include charges in excess of the Maximum Allowable Amount or any non-covered services. Refer to the Schedule of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Copayments are required unless otherwise specified in this Certificate.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Payment Maximum - The maximum amount of payment for Covered Services for the time period or other limit specified in the Certificate or the Schedule of Benefits. Payment means the amount actually paid by us for services received from a Provider.

Pharmacy and Therapeutics (P&T) Committee - A committee of Physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Plan (We, Us, Our) - Community Insurance Company which provides or arranges for

Members to receive the Covered Services which are described in this Certificate.

Pre-Existing Condition - A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within 6 Months of the period ending on your Enrollment Date. Pregnancy is not considered a Pre-Existing Condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Premium - The periodic charges which the Subscriber or the Group must pay the Plan to maintain coverage.

Prescription Legend Drug - A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Certificate.

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

Prior Authorization - The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities:

- **Alcoholism Treatment Facility** - A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** - a non-Hospital health care facility, or an attached facility designated as free standing

by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

- Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
 - Surgery;
 - Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians, which:
 - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
 - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
 - Does not provide Inpatient accommodations; and
 - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
 - **Certified Nurse Midwife**
 - **Certified Registered Nurse Anesthetist (C.R.N.A.)**
 - **Dialysis Facility** - A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or home care basis.
 - **Drug Abuse Treatment Facility** - A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
 - **Home Health Care Agency** - A facility which:
 - Provides skilled nursing and other services on a visiting basis in the Subscriber's home; and
 - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
 - **Home Infusion Facility** - A facility which provides a combination of:
 - Skilled nursing services
 - Prescription Drugs
 - Medical supplies and appliances

in the home as Home Infusion Therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
 - **Hospice** - A facility Provider which provides medical, social, psychological, and spiritual care as palliative treatment for terminally ill patients in the home and/or as an Inpatient using an interdisciplinary team of professionals.
 - **Hospital** - An institution which maintains an establishment for the medical or surgical care of bed patients for a continuous period longer than twenty-four hours and which:
 - Is open to the general public twenty-four hours each day for Emergency care; and
 - Has a minimum of ten patient beds; and
 - Has an average of two thousand patient days per annum; and
 - Has on duty a Registered Nurse twenty-four hours each day; and
 - Is not primarily providing psychiatric, rehabilitative, drug or alcoholism treatment.
 - **Laboratory (Clinical)**
 - **Licensed Practical Nurse (L.P.N.)**
 - **Occupational Therapist**

- **Outpatient Psychiatric Facility** - A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
 - **Pharmacy** - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
 - **Physical Therapist**
 - **Physician** - one of these professionals licensed under applicable State laws:
 - Doctor of Medicine (M.D.)
 - Doctor of Osteopathy (D.O.)
 - Podiatrist or Surgical Chiropracist (D.P.M. or D.S.C.)
 - Dental Surgeon (D.D.S.)
 - Chiropractor (D.C.)
 - Doctor of Optometry (O.D.)
 - **Psychiatric Hospital** - A facility which, for compensation of its patients, is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of Mental Health Disorders. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
 - **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
 - **Registered Nurse**
 - **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
 - **Respiratory Therapist**
 - **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:
 - Mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
 - Provides care supervised by a Physician;
 - Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
 - Is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
 - Is not a rest, educational, or Custodial Provider or similar place.
 - **Social Worker (licensed)**
 - **Speech Therapist**
 - **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Medical Supplies**
 - **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.
- Recovery** - A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist," "Underinsured Motorist," "Medical-Payments," "No-Fault," or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your

representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Certificate.

Service Area - The geographical area within which Our Covered Services are available, as approved by state regulatory agencies.

Single Coverage - Coverage for the Subscriber only.

Skilled Care - Care which must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is available 24 hours per day and usually involves a treatment plan.

Stabilize - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an Emergency department or other care setting where Emergency Care is provided to you;

- Your transfer from an Emergency department or other care setting to another facility; or
- Your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor - The Plan 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 and 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 - An employee or member of the Group who is eligible to receive benefits under the Group Contract.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the Covered Services section.

5 ELIGIBILITY AND ENROLLMENT

Coverage provided under this Certificate is made available to you because of your employment with or membership with or retirement from the Group.

In order for you to participate in the Group's benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods, and Actively At Work standards. The specific time periods and other standards for participation in the Group's benefit plan are determined by the Group, or state and/or federal law, and approved by Us. Eligibility requirements are described in general terms below.

For more specific eligibility information, you should see your Human Resource or Benefits department.

Eligibility

Unless We and the Group agree otherwise and notify you accordingly, the following eligibility rules apply:

Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be an employee of the Group who is entitled to participate in the benefit plan arranged by the Group, who has satisfied any probationary or waiting period established by the Group who is Actively At Work, and meets the eligibility criteria stated in the Group Contract.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group and be:

- The Subscriber's legal spouse.
- The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same sex who has signed the Domestic Partner Affidavit certifying that: he or she is the Subscriber's or the Eligible Person's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor Eligible Person is related by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber or Eligible Person.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's unmarried child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law which applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, COB.

A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary public. The Administrator reserves the right to make the ultimate decision in determining eligibility of the Domestic Partner.

- The Subscriber's or the Subscriber's spouse's unmarried children, including stepchildren, newborn and legally adopted children. The event date for an adopted child is the earlier of the date of adoption or date of placement for adoption. Placement for adoption means the assumption and retention of legal obligation for total and partial support for a child in anticipation of adoption of such child (included are natural children, adopted children and children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law).
- Unmarried children of the Subscriber or the Subscriber's spouse if the Dependent child is allowed as a federal tax exemption, up to the Dependent age limit shown in the Schedule of Benefits.
- Unmarried children for whom the Subscriber or the Subscriber's spouse is a legal guardian. The Subscriber must submit an application within 31 days of the date legal guardianship is approved by the court.

All enrolled eligible, unmarried children will continue to be covered until the age limit listed in the Schedule of Benefits.

Eligibility will be continued past the age limit only for those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or physical handicap. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

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

To obtain coverage for children, We may require that the Subscriber complete a "Dependency Affidavit" and provide Us with a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under this Certificate.

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

Coverage Effective Dates and enrollment requirements are described in the Group Contract.

Enrollment

Persons who are eligible to enroll as Members must enroll at the time agreed upon by the Plan. Otherwise, they may be subject to the terms of a Late Enrollment or Special Enrollment as set forth in the Group Contract, whichever is applicable.

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. That application must be received by the date established by the Group Contract or the Plan's underwriting rules for initial application for enrollment. If We do not receive the initial application by this date, the Eligible Person can only enroll for coverage under Late Enrollment period or during a Special Enrollment period, whichever is applicable.

If a Dependent of the Eligible Person qualifies as a Dependent under the Plan at the time of the Eligible Person's initial application for enrollment, but does not enroll, that person can only enroll for coverage under Late Enrollment period or during a Special Enrollment period, whichever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on Eligible Dependents.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for illness or injury for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days only if the Subscriber submits through the Group, or the Plan, a request to add the child under the Subscriber's Certificate. The request must be submitted within 31 days after the birth of the child. Failure to notify the Plan during this 31 day period will result in no coverage for the newborn beyond the first 31 days, except as permitted for a Late Enrollee.

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal guardianship for a child, an application must be submitted within 31 days of the date legal guardianship is awarded by the court or the child will be treated as a Late Enrollee. Coverage will be effective on the date the court approves legal guardianship if We receive an application within 31 days of that qualifying event.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under this Certificate, We will permit your child to enroll at any time without regard to any open enrollment limits and will provide the benefits of this Certificate in accordance with the order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Certificate will be paid, at Our

discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Portability

Any Pre-Existing Condition waiting period will be reduced by the aggregate of the periods of prior Creditable Coverage applicable to you as of your Enrollment Date under this Plan. Creditable Coverage is prior coverage you had from: a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plan or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan. You have the opportunity to prove that you have prior Creditable Coverage and We will assist you in obtaining that information if required.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If We receive an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage as a Late Enrollee. Application forms are available from the Plan.

Late Enrollment

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or Special Enrollment period, or as a newly eligible Dependent who failed to qualify during the Special Enrollment period and did not enroll within 31 days of the date during which the individual was first entitled to enroll is considered a Late Enrollee and may only apply for coverage as a Late Enrollee during the Group's next annual enrollment.

Notice of Changes

The Subscriber is responsible to notify the Group of any changes which will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Plan must be notified of any changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. Failure to notify Us of persons no longer eligible for services will not obligate Us to provide such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to provide such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Group must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

If the Plan determines that the Member is not eligible for coverage, the Plan may cancel that Member's coverage immediately. The termination date shall be retroactive to the date the person was no longer eligible. The Plan has the right to bill the Subscriber for the cost of any services provided

to such person during the period such person was not eligible under the Subscriber's coverage.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability or age.

Effective Date of Coverage

For information on your specific Effective Date of Coverage under this Certificate, you should see your Human Resources or benefits department or contact Us.

When Your Coverage Starts

Coverage starts on the Effective Date for all Members.

Continuous Coverage

If your Group moves from one Anthem Blue Cross Blue Shield plan to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately prior to enrolling in this product with no break in coverage, then any maximums, including Lifetime Maximums, when applicable, will be carried over and charged against the maximums and/or Lifetime Maximum under this Certificate.

If your Group offers more than one Anthem product, and you change from one Anthem product to another with no break in coverage, you will receive credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any Lifetime Maximum will be carried over and charged against the Lifetime Maximum.

If your Group offers coverage through other products or carriers in addition to Anthem's, and you change products or carriers to enroll in this Anthem product with no break in coverage, you will receive credit for any accrued Deductible, out of Pocket, and Lifetime Maximum amounts.

THIS SECTION DOES NOT APPLY TO YOU IF YOU:

- Change from an individual Anthem Blue Cross Blue Shield policy to a group Anthem Blue Cross Blue Shield plan;
- Change employers and both have Anthem Blue Cross Blue Shield coverage; or
- Are a new Member of the Group who joins the Group after the Group's initial enrollment with Anthem. Such new Members will receive credit from their prior carrier as described in the Portability section.

Statements and Forms

Members or applicants for membership shall complete and submit to the Plan applications, medical review questionnaires, or other forms or statements the Plan may reasonably request. Members represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete, and all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any misrepresentation by the member may result in termination of coverage as provided in the Termination of Coverage provision.

Delivery of Documents

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

Out of Service Area Dependent Child Coverage

Benefits for Covered Services will be provided for enrolled Dependent children who reside outside of the Service Area due to such children attending an out of Service Area educational institution or residing with the Subscriber's former spouse. Payment of benefits for these additional Covered Services is limited to the Maximum Allowable

Amount. You may be responsible for any amount in excess of the Maximum Allowable Amount.

6 TERMINATION, CONTINUATION AND CONVERSION

Termination

This Certificate of coverage is issued under a Group Contract which is guaranteed renewable at the option of the Group Contract holder. Termination of the Group Contract automatically terminates all your coverage as of the date of termination. It is the responsibility of the Group to notify you of the termination of the coverage. However, the coverage will be terminated, regardless of whether the notice is given.

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual Effective Date of termination may vary based on your Group's agreement with Us and your specific circumstances, such as whether premium has been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which We receive your notice of termination.
- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Certificate, your coverage generally will terminate on the last day of the billing period. The Group and/or you must notify Us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage then we may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed. You are responsible to pay Us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services. We will also terminate your Dependent's coverage, generally effective on the date your coverage was terminated. We will notify the Group in the event We terminate your and your Dependent's coverage.
- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.
- If you elect coverage under another carrier's health benefit plan or under any other non-Anthem plan which is offered by, through, or in connection with, the Group as an option instead of this Plan, then coverage for you and your Dependents will generally terminate at the end of the billing period for which premium has been paid, subject to the consent of the Group. The Group agrees to immediately notify Us that you have elected coverage elsewhere.
- If you fail to pay or fail to make satisfactory arrangements to pay any amount due to Us or Providers (including the failure to pay required Deductibles and/or Copayments), We may terminate your coverage and may also terminate the coverage of all your Dependents, generally effective immediately upon Our written notice to the Group.
- If you permit the use of your or any other Member's Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage shall terminate immediately upon Our

written notice to the Group. Any Subscriber or Dependent involved in the misuse of an Identification Card will be liable to and must reimburse Us for the Maximum Allowable Amount for services received through such misuse.

Removal of Members

Upon written request through the Group, a Subscriber may disenroll any Member from this health benefit plan. If so requested, no benefits will be provided for Covered Services rendered after the Member's termination date.

Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the Group's request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Group's clerical error. However, the Group is liable to Us if We incur financial loss as a result of Group's clerical error.

Certification of Coverage

If your coverage under this Plan is terminated, you and your covered Dependents will receive a certification that shows your period of coverage under this health benefit plan. You may need to furnish the certification if you become eligible under another group health plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. You and your Dependents may request a certification within 24 months of losing coverage under this health benefit plan.

Continuation of Coverage

State Continuation Provisions

If the Subscriber's coverage stops due to an involuntary termination of employment, the Subscriber may be eligible to continue group coverage. The Subscriber is eligible for continuation of group benefits when at the time of termination the Subscriber meets all of the following criteria:

- Continuously covered by the Group Contract or a similar contract for the three month period immediately prior to termination of employment;
- Eligible for unemployment compensation;
- Not eligible for nor covered by Medicare; and
- Not eligible for any other group medical coverage.

If the Subscriber is eligible for continuation of group benefits, coverage for the Subscriber and his/her eligible Dependents may continue for up to six months following termination of employment. This continuation of coverage applies only to health coverage and is contingent upon the Subscriber's payment of the required premium.

Contact your personnel office for information on continuation of group coverage before your last day of work.

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under an Employer which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health plan. It can also become available to other Members of your family, who are covered under the Employer's health plan, when they would

otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Employer's health plan, you should contact the Employer.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Employer's health plan is lost because of the qualifying event. Under the Employer's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for Fee payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Employer's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Employer's health plan as a "Dependent child."

If Your Employer Offers Retirement Coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Employer's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Employer's health plan.

When is COBRA Coverage Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then you must notify the Employer of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified

beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Employer's health plan is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Employer. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets

divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Employer's health plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Employer's health plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting Employer health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Conversion

During the last 180 days of the continuation period, the qualified beneficiary(s) who elect(s) continuation coverage will have the option of converting to individual conversion coverage in accordance with the Conversion provision of this Certificate.

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 1984, as amended and state law.

"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 by notifying your employer in advance and 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 Member 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:

1. The 18 month period beginning on the first date of your absence from work. The eighteen month continuation of coverage can be extended to a thirty-six month period if any of the following occurs during the eighteen month period:

- the death of the Reservist;
- the divorce or separation of a Reservist from the Reservist's spouse; or
- the cessation of dependency of a child pursuant to the terms of the Contract, ; or

2. 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) will be reinstated under this Certificate. No Exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the

Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must provide the Plan with evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

Conversion

If you have been continuously covered under the Group Contract for at least one year and your group coverage ends, you may have an option to purchase conversion coverage.

An option to purchase a conversion coverage is available to:

- a Subscriber when group coverage ends due to termination of the Subscriber's employment in the Group. The conversion policy may cover the Subscriber and Dependents;
- a surviving spouse when coverage ends due to death of the Subscriber. The conversion coverage may cover the spouse and children who are Dependents;
- a Subscriber's spouse whose coverage ends

due to divorce, dissolution or annulment of marriage;

- a child who ceases to be a Dependent due to attainment of the maximum age limit; or
- a Dependent whose coverage terminated because the Subscriber moved outside of the Service Area, if that Dependent still lives in the Service Area.

You are not eligible for conversion coverage if:

- you are eligible for benefits under Medicare or under state, federal or other insurance which duplicates Medicare benefits; or
- you are eligible for group insurance.

The Plan will send you notice of your conversion option. Following that notice you must apply in writing to the Plan for conversion. That application must be submitted no later than:

- either thirty days after you receive notice that your coverage under this Certificate is cancelled; or,
- sixty days after your coverage stops under this Certificate if you did not get written notice of the conversion privilege from Us.

Conversion coverage will be different from the coverage provided under this Certificate. Federally Eligible Individuals have the option to convert to a basic or standard plan. You must pay for conversion coverage from the date you stop being a Subscriber under this Certificate. If you pay from that date, your coverage under the conversion contract will start on the date the coverage under this Certificate stops.

7 HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers; however, the broadest benefits are

provided for services obtained from Network Providers. **Services you obtain from any Provider other than a Network Provider which are not an Authorized Service or**

Emergency Care are considered a Non-Network Service. Contact your Network Provider or Us to be sure that Prior Authorization and/or Precertification has been obtained.

Network Services and Benefits

If your care is rendered by a Network Provider benefits will be provided at the Network level. No benefits will be provided for care that is not a Covered Service even if performed by a Network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service.

Network Providers - include Physicians, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you.

For services rendered by Network Providers:

- The highest benefit payment is available through Network Providers or for services performed as Emergency Care from any Providers.
- You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments and/or Deductibles. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full. You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Certificate.
- Network Providers are responsible for services which the Plan determines are not Medically Necessary.
- Health Care Management is the responsibility of the Network Provider.

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

Non-Network Services

Services which are not obtained from a Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is Emergency Care.

Non-Network Providers include all Providers who are eligible to provide Covered Services under the Certificate but who do not contract with the Plan.

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

- The difference between the actual charge and the Maximum Allowable Amount as defined in this Certificate in addition to any Deductibles and/or Copayments.
- Services that are not Medically Necessary.
- Obtaining any Precertification which is required.
- Filing claims.
- Higher cost sharing amounts.

Coronary Services Centers

You are encouraged to use the Coronary Services Centers when you require certain non-Emergency cardiac care. Hospitals that are selected to participate as a Coronary Services Center have undergone a rigorous evaluation process. Contact Us as soon as your Physician suggests that your cardiac condition may require treatment. Precertification is required for non-Emergency Inpatient admissions for cardiac care. We encourage you to obtain services from a Coronary Services Center. If at any time you experience life-threatening cardiac symptoms, such as chest pains or shortness of breath, do not hesitate to seek care immediately at the nearest Hospital. Please refer to the Emergency Care section in this Certificate for further information.

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval

and are required to travel more than 75 miles from your residence to reach the nearest Coronary Services Center. Our assistance with travel expenses includes transportation to and from the nearest Coronary Services Center, lodging and meals. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

Services not available within the Service Area

If a Member requires treatment which is not available from a Network Provider within the Service Area, the Plan will cover that treatment from a Non-Network Provider subject to the same Copayments that apply for Network Providers.

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence as a result of services not being available within the Network. Our assistance with travel expenses includes transportation to and from the nearest Network Provider facility, lodging and meals. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

You will not be required to pay more for medical services than if the services had been received from a Network Provider within the Service Area.

Relationship of Parties (Plan - Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or

employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

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

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider does or does not do.

Identification Card

Whenever you receive care from a Network Provider or other Provider, you must show your Identification Card. Possession of an Identification Card confers no rights to services and other benefits under this Certificate. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Premiums under this Certificate have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Certificate you will be responsible for the actual cost of such services or benefits.

8 HEALTH CARE MANAGEMENT

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources through Case Management and through Precertification review requirements which may be conducted either prospectively (Prospective Review), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management or to determine which services require Precertification, call the **Precertification telephone number** on the back of your Identification Card or refer to our website, www.anthem.com.

Members are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information relevant to the Member's Precertification request.

Your right to benefits for Covered Services provided under this Certificate is subject to certain policies, guidelines and limitations, including, but not limited to, Our clinical coverage guidelines, medical policy and Health Care Management features listed in this section.

A description of each Health Care Management feature, its purpose, requirements and effects on benefits is provided in this section.

Clinical Coverage Guidelines

Our Clinical Coverage Guidelines such as medical policy, preventive care clinical coverage guidelines, Precertification review guidelines, Concurrent review guidelines, and Retrospective review guidelines, reflect the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of Clinical Coverage Guidelines is to assist in the interpretation of Medical Necessity. However, the

Certificate and Group Contract take precedence over the Clinical Coverage Guidelines. Medical technology and standards of care are constantly changing and We reserve the right to review and update the Clinical Coverage Guidelines periodically.

Precertification

NOTICE: Precertification does NOT guarantee coverage for or the payment of the service or procedure reviewed. It is a confirmation of Medical Necessity only.

Precertification is a Health Care Management feature which requires that an approval be obtained from Us before incurring expenses for certain Covered Services. Our procedures and timeframes for making decisions for Precertification requests differ depending on when the request is received and the type of service that is the subject of the Precertification request.

Urgent Review means a review for medical care or treatment that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgement, or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment. The Plan, applying the prudent layperson standard, may determine that an Urgent Review should be conducted. Concurrent reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay for Inpatient admissions will be determined. Medical Necessity includes a review of both the services and the setting. The care will be covered according to your benefits for the number of days

approved unless our Concurrent review determines that the number of days should be revised. If a request is denied, the Provider may request a reconsideration. Our Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the Member's health requires an earlier decision.

Most Providers know which services require Precertification and will obtain any required Precertification. Your Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. Generally, the ordering Provider, facility or attending Physician will call to request a Precertification review ("requesting Provider"). We will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific Precertification request. The authorized representative can be anyone who is 18 years or older. For Urgent Reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on Our process for designating an authorized representative, call the **Precertification telephone number** on the back of your Identification Card.

You are responsible for obtaining Precertification for certain services you obtain:

- **from a Non-Network Provider; or**
- **from a Network Provider through the local Blue Cross and Blue Shield Plan if you are traveling or you live outside of the Service Area.**

When it is your responsibility to obtain Precertification, you should either:

- **verify that the Non-Network or Blue Card Provider obtains the required Precertification; or**
- **obtain the required Precertification yourself.**

If you or your Non-Network or Blue Card Provider do not obtain the required Precertification, a Retrospective review will be done to determine if your care was Medically Necessary.

If We determine the services you receive are not Medically Necessary under your Plan and you received your care from a BlueCard Provider or a Provider that does not have a Participation Agreement with Us, you will be financially responsible for the services.

For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 24 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a Participation Agreement with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Precertification Procedures

Prospective review means a review of a request for Precertification that is conducted prior to a Member's Hospital admission or course of treatment. For Prospective reviews, a decision will be made and telephone notice of the decision will be provided to the requesting provider, as soon as possible, taking into account the medical circumstances, but not later than two business days from the time the request is received by Us.

For Urgent reviews, telephone notice will be provided to the requesting Provider as soon as possible taking into account the medical urgency of the situation, but not later than two calendar days from the time the request is received by Us.

If additional information is needed to certify benefits for services, We will notify the requesting Provider by telephone and send written notification to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review as soon as possible, but not later than two business days after receipt of the request. For Urgent Reviews we will notify the requesting Provider by telephone of the specific information necessary to complete the review within 24 hours after receipt of the request by Us. Written notice will be sent following the request by telephone.

The requested information must be provided to Us within 45 calendar days from receipt of Our request. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. For Urgent Reviews, the requested information must be provided within 48 hours after Our request for specific information. A decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, but not later than two business days (two calendar days for Urgent Reviews) after Our receipt of the requested information.

If a response to Our request for specific information is not received or is not complete, a decision will be made based upon the information in Our possession and telephone notice of the decision will be provided to the requesting Provider not later than two business days (two calendar days for Urgent Reviews) after the expiration of the period to submit the requested information. Written notice of Prospective review decisions will be provided to you and your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

Concurrent Review

Concurrent review means a review of a request for Precertification that is conducted during a Member's Inpatient Hospital stay or course of treatment. As a result of Concurrent review, additional benefits may be approved for care which exceeds the benefit(s) originally authorized

by Our Health Care Management staff.

If a request for Concurrent review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for Urgent Review, a decision will be made and telephone notice of the decision will be provided to the requesting Provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by Us. If the request is not received within 24 hours prior to the end of the approved care, the decision will be made and telephone notice of the decision will be provided to the requesting Provider within two calendar days, but not greater than one business day, from the time the request is received by Us.

For Concurrent reviews that do not qualify for Urgent Review, the decision will be made and telephone notice will be provided to the requesting Provider within one business day from the time the request is received by Us.

If additional information is needed to certify benefits for services for a Concurrent review that does not qualify for Urgent review, We will notify the requesting Provider by telephone and will send written notice to you or your authorized representative and the requesting Provider of the specific information necessary to complete the review within one business day after receipt of the request. You or your authorized representative and the requesting Provider have 45 calendar days from receipt of Our request to provide the information to Us. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made and telephone notice of the decision will be provided to the requesting Provider within one business day from the time the requested information is received by Us. If a response to Our request for specific information is not received or is not complete, a decision will be made based upon the information in Our possession and telephone notice of the decision will be provided to the requesting Provider no later than one business day after expiration of the period to submit the requested information.

Written notice of Concurrent review decisions will be sent to you or your authorized representative and the Provider(s) within one

business day of the date the decision is rendered.

We will not reduce or terminate a **previously approved** on-going course of treatment until you or your authorized representative receive telephone notice of Our decision and have an opportunity to appeal the decision and receive notice of the appeal decision.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after health care services have been provided to a Member. If Precertification is required but not obtained prior to the service being rendered, We will conduct a Retrospective review. Further, if a service is subject to a clinical guideline, but Precertification is not required for that service, We may conduct a Retrospective review.

Retrospective review may be completed before a claim is submitted (pre-claim) or after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

For Retrospective review, a decision will be made within 15 calendar days from the time the request is received by Us (pre-claim) or within 30 calendar days from the time the claim is received by Us (post-claim). Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 15 calendar days from the time the request is received by Us (pre-claim) or 30 calendar days from the time the claim is received by Us (post-claim).

If additional information is needed to certify benefits for services, We will notify you or your authorized representative and the requesting Provider in writing of the specific information necessary to complete the review within 15 calendar days after receipt of the request (pre-claim) or 30 calendar days after receipt of the claim (post-claim).

For pre-claim Retrospective reviews, you or your authorized representative and the requesting

Provider have 45 calendar days from receipt of Our request to provide the information to Us

Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made within 15 calendar days from the time the requested information is received by Us. If a response to Our request for specific information is not received or is not complete, a decision will be made based upon the information in Our possession not later than 15 calendar days after expiration of the period to submit the requested information. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within 5 business days of the date the decision is rendered, but not later than 15 calendar days of receiving the requested information or 15 calendar days of the expiration of the time period for submitting the information whichever occurs first.

For post-claim Retrospective reviews, you or your authorized representative and the requesting Provider have a reasonable amount of time taking into account the circumstances, but not less than 45 calendar days from the date of Our request to provide the additional information to Us. A decision will be made within 15 calendar days from the time the requested information is received by Us. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 15 calendar days of receiving the requested information.

Case Management (includes Discharge Planning)

Case Management is a Health Care Management feature designed to promote the most appropriate and cost effective care setting. This feature allows Us to customize your benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by Our Health

Care Management staff. In managing your care, We have the right to authorize substitution of Outpatient Services or services in your home to

the extent that benefits are still available for Inpatient Services.

9 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **Care must be received from a Network Provider to be covered at the Network level, except for Emergency Care and Urgent Care. Services which are not received from a Network Provider will be considered a Non-Network Service, unless otherwise specified in this Certificate.** The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment or Deductible. We cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Certificate, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider 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. To receive Maximum benefits for Covered Services, you must follow the terms of the Certificate, including use of Network Providers, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization/Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines.

We 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.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate. Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Copayment, Deductible, Benefit Period maximum, or Lifetime Maximum in this Certificate.

Preventive Care Services

Preventive Care benefits may vary based on the age, sex, and personal history of the individual, and as determined appropriate by Our clinical coverage guidelines. Screenings and other services are generally 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.**

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. **(Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports**

programs, or for other purposes, are not Covered Services.) Examinations include, but are not limited to:

1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services include, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
 2. Adult routine physical examinations.
 3. Pelvic examinations.
 4. Routine EKG, Chest X-Ray, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
 5. Annual dilated eye examination for diabetic retinopathy.
- Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, we follow the Adult Immunization Schedule by age and medical condition as approved by the advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians. These include, but are not limited to:
 1. Hepatitis A vaccine
 2. Hepatitis B vaccine
 3. Hemophilus influenza b vaccine (Hib)
 4. Influenza virus vaccine
 5. Rabies vaccine
 6. Diphtheria, Tetanus, Pertussis vaccine
 7. Mumps virus vaccine
 8. Measles virus vaccine
 9. Rubella virus vaccine
 10. Poliovirus vaccine
 - Screening examinations:
 1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts;
 2. Routine hearing screening;
 3. Routine screening mammograms. The total benefit for a screening mammography under this Plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty percent (130%) of the Medicare reimbursement rate in the State of Ohio for a screening mammography;
 4. Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test);
 5. Routine bone density testing for women;
 6. Routine prostate specific antigen testing;
 7. Routine colorectal cancer examination and related laboratory tests.
 - Diabetes self management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition:
 1. Medically Necessary;
 2. Ordered in writing by a Physician or a podiatrist; and

3. Provided by a Health Care Professional who is licensed, registered, or certified under state law.

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

Physician Office Services

Office Services include care in a Physician's office that is not related to Maternity and Mental Health/Substance Abuse Services, except as specified. Refer to the sections entitled **Maternity Services** and **Mental Health/Substance Abuse Services** for services covered by the Plan. **For Emergency Accident or Emergency Medical Care refer to the Emergency Care and Urgent Care section.**

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include injections, serum and allergy testing. When an allergy injection, testing or allergy serum is the only charge from a Physician's office, a specific Copayment may apply as stated in the Schedule of Benefits under Physician Office Services.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical services including anesthesia and supplies. The surgical fee includes normal post-operative care.

Therapy Services for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

Inpatient Services

Inpatient Services do not include care related to Maternity and Mental Health Services, except as specified. Refer to the sections for **Maternity**

Services and Mental Health/Substance Abuse Services for services covered by the Plan. Inpatient Services include:

- Charges from a Hospital or other Provider for Room, Board and General Nursing Services;
- Ancillary Services; and
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Provider's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs;
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Facility Provider;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services;
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded.
- **Surgery and the administration of anesthesia.**
- **Newborn examinations** by a Physician other than the Physician who performed the obstetrical delivery.

Copayment Waiver

When a Member is transferred from one Hospital or other facility Provider to another Hospital or other facility Provider on the same day, any Copayment stated in dollars per admission in the Schedule of Benefits is waived for the second admission. Copayments stated as a percentage are not waived.

Outpatient Services

Outpatient Services include both facility and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. Outpatient Services do not include care that is related to Maternity or Mental Health/Substance Abuse Services, except as otherwise specified. Refer to the sections for Maternity Services and

Mental Health/Substance Abuse Services for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if stated in dollars. Any Copayment stated as a percentage will still apply to these services.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Emergency Care and Urgent Care

Emergency Care (including Emergency Room Services)

Medically Necessary services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment or Deductible. In addition, if you contact your Physician and are referred to a Hospital Emergency Room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, seven (7) days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonable appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs, Physician services, and supplies and Prescriptions.

Whenever you are admitted as an Inpatient directly from a Hospital Emergency room, the

Emergency Room Services Copayment for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 24 hours or as soon as possible within a reasonable period of time. When we are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a Participation Agreement with Us or is a BlueCard Provider, you may be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network benefit unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment. Urgent Care services can be obtained from a Network or Non-Network Provider. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not an Emergency and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent

medical problem and your Physician authorizes you to go to an Emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

Obtaining Emergency or Urgent Care

If you need Emergency Care or Urgent Care even while you are traveling outside of our Service Area, these are the step-by-step instructions you need to follow to help ensure you receive coverage.

- Know the difference between an Emergency and an Urgent Care situation.
- If you are experiencing an Emergency situation, call 9-1-1 or go to the nearest Hospital. If you are experiencing an Urgent Care medical problem, go to an Urgent Care center. If there is not one nearby, then go to the Hospital.
- Call your Physician or Us within 24 hours.
- Ask if the Hospital or Urgent Care center contracts with the local Blue Cross and Blue Shield Plan.
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, show your Identification Card to the Hospital or Physician. If it does not contract with the local Blue Cross and Blue Shield Plan, you will need to pay the bill and file a claim form.
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, the Hospital or Urgent Care Center will verify your membership and get your benefit information from a nationwide electronic data system.
- After you are treated, your claim is sent to Us. You only have to pay the Hospital or Urgent Care Center any Copayments or Deductibles as stated in your Plan.
- You may receive an Explanation of Benefits form depending on what services you received.

Travel outside the country:

- Go to the nearest health care facility.
- Call your Physician or Us within 24 hours.
- Once your care is completed, you will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for you.) **Keep all your receipts!**
- When you return home, call Us at the number on the back of your ID card or stop by your Group's personnel office and ask for a claim form.
- Fill out the claim form and submit it with your receipts to Our address on the form. (The amount submitted must be in American dollars.)
- You will be reimbursed based on the benefits of your Plan.

Ambulance Services

Transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between Hospital and Skilled Nursing Facility;
- From a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire, or public safety official and the Member is not in a position to refuse; or
- When a Member is required by Us to move from a Non-Network Provider to a Network Provider.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

Mental Health/Substance Abuse Services

Covered Services include but are not limited to:

- **Inpatient services**-individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. Room and board charges are Covered Services only when Our Subcontractor or We authorize an Inpatient stay.
- **Partial hospitalization**-a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least 4 to 6 hours of treatment per day. Patients are expected to participate up to 5 days per week.
- **Intensive outpatient treatment or day treatment**-a structured program, offered at least 3 times per week for at least 3 hours per day. The program may be managed by a licensed mental health professional with a psychiatrist on staff. Therapy is provided by a licensed mental health professional.
- **Outpatient treatment, or individual or group treatment**-office-based services, for example diagnostic evaluation, counseling, psychotherapy, family and marital therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

Non-Covered Mental Health/Substance Abuse Services

- Residential Treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Custodial or Domiciliary care.
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets our Medical Necessity criteria for Inpatient admission for your condition.

We encourage you to contact Our Mental Health/Substance Abuse Services Subcontractor to verify the use of appropriate procedures, setting and Medical Necessity. When you obtain prior approval from Our Mental Health/Substance Abuse Services Subcontractor and receive services from the Provider designated by that approval, Covered Services will be considered a Network service. If you do not obtain prior approval, Covered Services will be considered a Non-Network service.

Diagnostic Services

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Preventive Care Services, Physician Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is included but is limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Magnetic Resonance Imaging (MRI);
- CAT scans;
- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope tests;
- Ultrasound services;
- Allergy tests;
- Electrocardiograms (EKG);
- Electromyograms (EMG) except that surface EMG's are not Covered Services;
- Echocardiograms;
- Bone density studies;
- Positron emission tomography (PET scanning);
Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

When Diagnostic radiology is performed in a Network Physician's Office, no Copayment is required if stated in dollars. Any Copayment stated as a percentage will still apply.

See the Schedule of Benefits for benefit limitations.

Surgical Services

Coverage for Surgical Services when provided as part of Physician Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;

- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; and
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Mastectomy Note: A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications of all stages of the mastectomy, including lymphedemas.

Sterilization: Regardless of Medical Necessity, you are covered for sterilization.

Therapy Services

Benefits for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Facility Services, or Home Care Services is limited to the following:

Physical Medicine Therapy Services-The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).
- **Spinal manipulation services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Spinal Manipulations as specified in the Schedule of Benefits.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.

- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Physical Medicine and Rehabilitation Services

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

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

Home Care Services

Services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services may include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services
- Therapy Services (Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home);
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)

Home infusion therapy is covered and includes a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and/or administered intravenously in the home. Home infusion therapy includes services and supplies for Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management, and chemotherapy.

Hospice Services

Hospice care may be provided in the home or Hospice facility for medical, social and psychological services used as palliative treatment for patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.)
- Diagnostic Services
- Physical, speech and inhalation therapies
- Medical supplies, equipment and appliances

- Counseling services (except bereavement counseling)
- Inpatient confinement at a Hospice
- Prescription Drugs obtained from the Hospice

Human Organ and Tissue Transplant Services

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services, or Physician Office Services depending on where the service is performed.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblastic therapy.

Covered Transplant Services

All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Notification

We strongly encourage the Member to call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. We will then assist the Member in maximizing their benefits by providing coverage information

including details regarding what is covered and whether any Medical Policies, Network requirements or Certificate Exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for 364 days. If, within this time frame, a second Covered Transplant Procedure occurs, the Covered Transplant Benefit Period will begin one day prior to the second Covered Transplant Procedure and continue for 364 days.

Transportation, Meals and Lodging

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

Medical Supplies, Durable Medical Equipment, and Appliances

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or to treat your condition, reimbursement will be based on the Maximum

Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. **For example**, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Covered Services include, but are not limited to:

- **Medical and surgical supplies**-Syringes, needles, oxygen, surgical dressings, splints, and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like Band-Aides, thermometers, and petroleum jelly. Prescription drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depro-Provera;
- **Durable medical equipment**-The rental (or, at Our option the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. Non-covered items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports, and corsets or other articles of clothing.
- **Prosthetic appliances**-Artificial substitutes for body parts and tissues and materials inserted into tissues for functional

or therapeutic purposes. Covered Services include purchases, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Covered Services for prosthetic appliances include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power source, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant)
3. Breast prosthesis whether internal or external, following a mastectomy, and two surgical bras per Benefit Period, required by the Women's Health and Cancer Rights Act;
4. Minor devices for repairs such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session):

7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract-formulae and supplies are also covered)
8. Cochlear implant;
9. Electronic speech aids in post-laryngectomy or permanently inoperative situations;
10. Space Shoes when used as a substitute device when all or a substantial portion of the forefoot is absent;
11. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).
See the Schedule of Benefits for benefit limitations.

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth;
 2. Dental appliances;
 3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
 4. Artificial heart implants;
 5. Hairpieces for male pattern alopecia (baldness);
 6. Wigs (except as described above following cancer treatment):
- **Orthotic devices**-Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fitting, and adjustments are included.

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

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

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

Non-Covered Services include but are not limited to:

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

Dental Services

Related to Accidental Injury

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. Initial

dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

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

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

Non-covered services for accidental dental include, but are not limited to:

- Charges for any Investigative/Experimental treatment, procedure, facility, equipment, drug, device, or supply;
- Surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin), except for reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process.

Other Dental Services

The only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Maternity Services

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician or the nurse midwife in applicable cases, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
 1. the antepartum, intrapartum, and postpartum course of the mother and infant;
 2. the gestational stage, birth weight, and clinical condition of the infant;

3. the demonstrated ability of the mother to care for the infant after discharge; and
4. the availability of postdischarge follow-up to verify the condition of the infant after discharge.

- **Covered Services include at-home post delivery follow-up care visits** at your residence by a Physician or Nurse when performed no later than seventy-two (72) hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

1. parent education;
2. physical assessments;
3. assessment of the home support system;
4. assistance and training in breast or bottle feeding; and
5. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

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

Prescription Drugs

Anthem Prescription Management

The Pharmacy benefits available to you under this Certificate are managed by Our affiliate, Anthem Prescription Management (APM). APM is a Pharmacy benefits management company with which We contract to manage your Pharmacy benefits. APM has a nationwide network of Retail Pharmacies, a Mail Service Pharmacy, and provides clinical services that include Formulary management.

The management and other services APM provides include, among others, making

recommendations to, and updating, the Formulary and managing a Network of Retail Pharmacies and operating a Mail Service Pharmacy. APM, in consultation with Us, 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.

You may review a copy of the current Formulary on Our website at: www.AnthemPrescription.com. You may also request a copy of the Formulary by calling Us at the Customer Service telephone number on the back of your Identification Card. The Formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary is not a guarantee of coverage. Refer to the Prescription Drug benefit sections in this Certificate for information on coverage, limitations and exclusions.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before APM and/or the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular drug). 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 Us or APM. We, or APM, uses pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee and reviewed and adopted by Us. We, or APM, communicates the results of the decision to the pharmacist. We, or APM, 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 Complaint and Appeals Procedures section of this Certificate.

For a list of the current drugs requiring Prior Authorization, please contact Us at the Customer Service telephone number on the back of your ID card or consult APM's website at: www.AnthemPrescription.com. The Formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary is not a guarantee of coverage. Refer to the Prescription Drug benefit sections in this Certificate for information on coverage, limitations and Exclusions. Please ask your Provider or Network pharmacist to check with Us or with APM to verify Formulary Drugs, any quantity and/or age limits, or appropriate brand or Generic Drugs recognized under the Plan.

Covered Prescription Drug Benefits

Covered Services include only:

- Prescription Legend Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment. Contact Us to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Durable Medical Equipment and Appliances instead of under Prescription Drug Benefits.
- Oral contraceptive drugs are covered when obtained through an eligible Pharmacy.
- Human growth hormones (whether natural or synthetic), require Prior Authorization.
- Injectables.

- Therapeutic Substitution of Drugs is a program approved by Us and managed by APM. This is a voluntary program designed to inform Members and Physicians about Formulary or Generic alternatives to non-Formulary and Formulary Brand drugs. We, or APM, may contact you and your prescribing Physician to make you aware of Formulary or Generic Drug substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For a list of therapeutic drug substitutes that have been identified, contact Us by calling the Customer Service telephone number on the back of your ID card. You may also review the list of therapeutic drug substitutes on APM's website at: www.AnthemPrescription.com. The therapeutic drug substitutes list is subject to periodic review and amendment.

Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Certificate for other non Covered Services)

- Drugs, devices and products or Prescription Legend Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by Us or APM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Charges for the administration of any drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to drugs used in conjunction with a

Diagnostic Service, with chemotherapy performed in the office; or drugs eligible for coverage under the Medical Supplies benefit.

- Any drug which is primarily for weight loss, except certain drugs for the treatment of morbid obesity may be Covered Services based on Medical Necessity.
- Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law) except for injectable insulin.
- Drugs in quantities which exceed the limits established by the Plan or which exceed any age limits established by the Plan.
- Any drug which is primarily for cosmetic purposes (including, but not limited to, preserving, changing or improving your appearance, such as changing the appearance or texture of your skin).
- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may in its sole discretion, waive this Exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend drugs, are payable as medical supplies based on where the services is performed or the item is obtained. If such items are over the counter drugs, devices or products, they are not Covered Services.
- Related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This includes Prescription Drugs and all other procedures and equipment developed for or used in the treatment of impotency.

- Fertility drugs.

Copayment - Each Prescription Order may be subject to a Copayment. If the Prescription Order includes more than one covered drug, a separate Copayment will apply to each covered drug. Your Prescription Drug Copayment will be the lesser of your scheduled Copayment amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for the applicable Deductible and/or Copayment. If you receive Covered Services from a Non-Network Pharmacy, a Deductible and/or Copayment amount will also apply.

Days Supply - The number of days supply of a drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits.

Formulary - The Plan follows a drug Formulary in determining payment and Covered Services. You will be responsible for an additional Copayment amount depending on whether a Formulary or non-Formulary Drug is obtained. Please see the Schedule of Benefits.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, a Non-Network Pharmacy, or the Mail Service Program. It is also based upon whether you obtain a Generic or Brand Name Prescription Legend Drug and whether Formulary Prescription Legend Drugs were dispensed. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

Note: If you obtain a Brand Name Drug, the Brand Name Drug Copayment will always apply, even in the following situations:

- No Generic Drug equivalent is available;
- The Prescription Order specifies "Dispense as Written;" or
- You choose the Brand Name Drug instead of the Generic Drug Equivalent.

If you choose a Brand Name Drug, or your Provider prescribes a Brand Name Drug and a Generic Formulary Drug is available, you pay the Brand Formulary Drug Copayment. If you choose a Non-Formulary Drug, or your Provider prescribes a Non-Formulary Drug and a Generic Formulary Drug or Brand Formulary Drug is available, you pay the Non-Formulary Drug Copayment. Where no Generic Drug is available, you are only responsible for the applicable Formulary or Non-Formulary Drug Copayment.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by Us for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment for which you are responsible.

Your Copayment(s) and/or Deductible(s) will not be reduced by any discounts, rebates or other funds received by APM, the Subcontractor and/or the Plan from drug manufacturers or similar vendors.

For Covered Services provided by a Network Pharmacy or through Mail Service, you are responsible for all Deductibles and/or Copayment amounts.

For Covered Services provided by a Non-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment amounts. If you do not present your Identification Card, you will have to pay the full

retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Us with a written request for refund.

Non-Network Pharmacy – You are responsible for payment of the entire amount charged by the Non-Network Pharmacy. You must submit a Prescription Drug claim form to Us for reimbursement consideration. These forms are available from Us or from the Group. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to Us. The itemized receipt must show:

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

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

Anthem Mail Service – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible and/or Copayment amounts to the Mail Service when you request a prescription or refill.

10 EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services.

We do not provide benefits for procedures, equipment, services, or supplies:

1. Which We determine are not Medically Necessary or do not meet Our medical policy, Clinical Coverage Guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us;
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us;
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This Exclusion applies if you receive the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Certificate will be coordinated with such governmental units to the extent required under existing State or Federal laws;
6. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;
7. For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces;
8. For court ordered testing or care, unless Medically Necessary and authorized by Us.
9. For which you have no legal obligation to pay in the absence of this or like coverage;
10. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
11. Prescribed, ordered or referred by or received from a member of your immediate family, (parent, child, spouse, sister, brother, or self);
12. For completion of claim forms or charges for medical records or reports unless otherwise required by law;
13. For missed or canceled appointments;
14. For mileage costs or other travel expenses, except as authorized by Us;
15. For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except as specified elsewhere in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions; For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled. For Medicare Part D, We will calculate benefits as if the Member had enrolled in the Standard Basic Plan;
16. In excess of the Maximum Allowable Amount unless otherwise specified in this Certificate.

17. For any Pre-existing Condition for the time period specified in the Schedule of Benefits, subject to the Portability provision of this Certificate. This Exclusion is not applicable to newborns, adopted children or children placed for adoption who are enrolled under this Certificate within 31 days of the date of birth or placement for adoption;
18. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
19. Incurred prior to your Effective Date;
20. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate;
21. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law.
22. For services which are performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition which is resolved or stable;
23. For Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional;
24. For foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically Necessary including but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.
25. For any treatment for teeth, gums or tooth related service except as otherwise specified in this Certificate;
26. Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded, except for surgical treatment of morbid obesity. Weight loss programs include but are not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs;
27. For sex transformation surgery and related services, or the reversal thereof;
28. For marital counseling or personal growth.
29. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
30. For hearing aids or examinations for prescribing or fitting them;
31. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein;
32. For reversal of sterilization;

33. For artificial insemination; fertilization (such as invitro or GIFT) or procedures and testing related to fertilization; infertility drugs and related services following the diagnosis of infertility.
34. For personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
35. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by Us.
36. For care received in an emergency room which is not Emergency Care.
37. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
38. 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 for left ventricular assist devices(LVAD) when used as a bridge to a heart transplant;
39. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST) and iridology-study of the iris.
40. At a health spa or similar facility.
41. For self-help training and other forms of non-medical self care, except as otherwise provided herein;
42. For research studies or screening examinations, except as specified elsewhere in this Certificate.
43. For stand-by charges of a Physician;
44. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes;
45. For Private Duty Nursing Services except when provided through the Home Care Services benefit.
46. For elective abortions accomplished by any means.
47. Related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency.
48. Any new FDA Approved Drug Product or Technology (**including but not limited to medications, medical supplies, or devices**) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this Exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology;

11 CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply.

If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

How Benefits Are Paid

This Plan shares the cost of your medical expenses with you up to the Maximum Allowable Amount.

Network Providers will seek compensation from Us for Covered Services. When using a Network Provider you are only responsible for Copayments, Deductibles, and non-covered charges. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full. If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual charge billed and the Maximum Allowable Amount plus any Deductible, Copayments, and non-covered charges. Copayments are your share of the cost for particular health services, and are generally due at the time you receive the medical service. For Covered Services subject to a Copayment, you pay a portion of the bill and the Plan pays its share of the balance. Refer to the Schedule of Benefits to see what Copayment is required for each Covered Service.

If you receive Covered Services in a Network Provider facility from a Non-Network Provider such as an anesthesiologist who is employed by or contracted with that Network Provider facility, benefits will be paid at the Network level. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full

under a Network Provider's participation agreement for this product. You may be liable for the difference between the billed charge and our Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the **Schedule of Benefits** to see what amount you are required to pay for each service. Claims for Covered Services need not be sent to us in the same order that expenses were incurred.

We will deny that portion of any charge which exceeds the Maximum Allowable Amount.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Certificate. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

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

Assignment

This Certificate is not assignable by the Group without the written consent of the Plan. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of the Plan, except as described in this Certificate.

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

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

Note: Under Ohio law, you have the right to obtain an itemized copy of your billed charges from the Hospital or Facility which provided services.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within

15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Member's Cooperation

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

Plan Information Practices Notice

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

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.

- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

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

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

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Certificate. You must exhaust the Plan's appeal procedures before filing a lawsuit or other legal action of any kind against the Plan.

BlueCard Program

When you obtain health care services through the BlueCard Program outside the geographic area We

serve, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto Us.

Often this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, We would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

12 GENERAL PROVISIONS

Entire Contract

Note: The laws of the state in which the Group Contract was issued will apply unless otherwise stated herein.

This Certificate, the Group Contract, the Group application, any riders, Endorsements or attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

Form or Content of Certificate

No agent or employee of the Plan is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done

consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits

All benefits provided under this Certificate are subject to Coordination of Benefits except, Prescription Drug Benefits.

Coordination of Benefits (COB) is the procedure used when a Member has health care benefits under more than one health care coverage. This Plan follows rules established by law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another plan in addition to this one, this Plan will follow Coordination of Benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

This Plan pays for health care only when you follow its rules and procedures. If its rules conflict with those of another plan, it may be impossible to receive benefits from both plans and you will be forced to choose which plan to use.

Plans That Do Not Coordinate

This Plan will pay benefits without regard to benefits paid by the following kinds of coverage.

- Medicaid
- Group Hospital indemnity plans which pay less than \$100 per day
- School accident coverage
- Some supplemental sickness and accident policies

How This Plan Pays When Primary

- When this Plan is primary, it will pay the full benefit allowed by this Certificate as if you had no other coverage.

How This Plan Pays When Secondary

- When this Plan is secondary, its payments will be based on the balance left after the primary plan has paid. It will pay no more than that balance. In no event will this coverage pay more than it would have paid if it had been primary.
- This Plan will pay only for health care expenses that are Covered Services in this Certificate.

- This Plan will pay only if you have followed all of our procedural requirements, including care obtained from or arranged by your Primary Care Physician, if applicable, etc.
- This Plan will pay no more than the "allowable expenses" for the health care involved. If this Plan's allowable expense is lower than the primary plan's, then the primary plan's allowable expense will be used unless a Provider has agreed to accept this Plan's allowable expense as payment in full. The allowable expense may be less than the actual bill.

Which Plan Is Primary

To decide which plan is primary, consider both the coordination provisions of the other plan and which member of your family is the patient. The primary plan will be determined by the first of the following which applies:

1. Non-coordinating Plan

If you have another group coverage which does not coordinate benefits, that plan will always be primary.

2. Insured / Employee

The plan which covers the patient as the insured is primary to the plan which covers the person as a Dependent; except, if that person is also a Medicare beneficiary and as a result of Medicare regulations, Medicare is:

- a. secondary to the plan covering the person as a Dependent; and
- b. primary to the plan covering the person as other than a Dependent (e.g. a retiree).

3. Children (Parents Divorced or Separated)

If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.

If the court decree gives joint custody and does not mention health care, this Plan follows the birthday rule.

If neither of these rules apply, the order will be determined in following order:

- a. The plan of the parent with custody;
- b. The plan of the spouse of the parent with custody;
- c. The plan of the parent not having custody; and
- d. The plan of the spouse of the parent not having custody.

4. Children and the Birthday Rule

When your children's health care expenses are involved, the "birthday rule" is followed. The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children. If the parents' birthdays are the same, then whichever parent's plan has been in effect longer is primary.

However, if your spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's coverage is always primary), then the rules of that plan will be followed.

5. Active Employment vs Layoff or Retirement

The plan which covers the person as an active employee (or that employee's Dependent) is primary to another plan which covers that person as a laid off employee or a retiree (or that person's Dependent). If both plans do not include this same rule, then it will be ignored. This rule does not supersede rule 2, insured vs. Dependent.

6. State or Federal Continuation Coverage

When the person's coverage is provided under a right of continuation under federal law (i.e. COBRA) or state law, any other plan covering that person will be primary to the plan covering the person under such continuation provision unless that other plan does not include this same rule.

7. Length of Time Covered by the Plan

The plan which has covered the person for the longer period of time is primary to another plan.

8. Other Situations

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

Right to Receive and Release Needed Information-Certain facts are needed to apply COB rules. We have the right to decide which facts are needed. We may get needed facts from or give them to any other organization or person. We need not tell you, or get your consent to do this. Each person claiming benefits under this Plan must provide any facts needed to pay the claim.

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

Right of Recovery-If the amount of the payments made by this Plan is more than should have been paid under this COB provision, we may recover the excess from one or more of:

- The persons it has paid or for whom it has paid;
- Another plan; or,
- The provider of service.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes-If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Us. Follow the steps described in the Complaint Procedure section of the Certificate.

If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1 (800) 686-1526.

Medicare

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

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

Worker's Compensation

The benefits under this Certificate are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Certificate.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- We are not responsible for any attorney fees, other expenses or costs you incur without Our prior written consent. We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.
- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 - The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
 - You fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider, vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which Recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue Recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the Recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Group-Member-Plan)

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan's notice to the Group will constitute effective notice to the Member. It is the Group's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or terminations.

Interpretation of Certificate

The laws of the State which issued the Certificate of Authority to the Plan shall be applied to the interpretations of this Certificate. Where applicable, the interpretation of this Certificate shall be guided by the pre-paid nature of the Plan's operations as opposed to a fee-for-service indemnity basis.

Modifications

By this Certificate, the Group makes the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the consent or concurrence of any Member. Any amendments are subject to approval by the Department of Insurance prior to use. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof.

Conformity with State Law

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

Clerical Error

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Certificate, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, has complete discretion to 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, Experimental-Investigative, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowable Amount. However, a Member may utilize all applicable Member Complaint and Appeals procedures.

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

Community Insurance Company Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate is part of a contract solely between the Group and Community Insurance Company (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Ohio. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trade mark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

13 COMPLAINT AND APPEALS PROCEDURES

Our customer service representatives are trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Copayment amounts,
- Specific claims or services you have received,
- Doctors or Hospitals in the Network,
- Referral processes or authorizations,
- Provider directories.

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that you may have concerning the Plan. The Plan invites you to share any concerns that you may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in Our Networks.

The Complaint Procedure

If you have a complaint, problem, or claim concerning benefits or services, please contact Us. Please refer to your Identification Card for Our address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from Us of Our procedures and your benefit document. You may submit your complaint by letter or by telephone call. If your complaint involves issues of Covered Services, you may be asked to sign a release of information form so We can request records for Our review.

You will be notified of the resolution of your complaint if a claim or request for benefits is denied in whole or in part. We will explain why benefits were denied and describe your rights under the Appeal Procedure.

Appeal Procedures

As a Member of this Plan, you have the right to appeal decisions to deny or limit your health care benefits. The explanation of why We denied your claim or request for benefits will describe the steps you should follow to initiate your appeal.

An appeal is a request from you for Us to change a previous determination or to address a concern you have regarding confidentiality or privacy.

Internal Appeals

An initial determination by Us can be appealed for internal review at two subsequent levels known as "Level 1" and "Level 2" appeals. The Plan will advise you of your rights to appeal to the next level if a denial occurs after an initial determination or Level 1 appeal.

You have the right to designate a representative (e.g. your Physician) to file appeals with Us on your behalf and to represent you in any level of the appeals process. If a representative is seeking an appeal on your behalf, We must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until Anthem has received the properly completed DOR form except that if a Physician requests expedited review of a Level 1 appeal on your behalf, the Physician will be deemed to be your designee for the limited purpose of filing for expedited review of the Level 1 appeal without receipt of a signed form. We will forward a Designation of Representation form to you for completion in all other situations.

Anthem will accept oral or written comments, documents or other information relating to an appeal from the member or the member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

To obtain information on Our appeal

procedures or to file an oral appeal please call the toll free customer service number listed on the back of your Plan Identification Card or the number provided for appeals on any written notice of an adverse decision that you receive from Us.

We will also accept appeals filed in writing. If you wish to file your appeal in writing, you must mail it to: Anthem Blue Cross and Blue Shield, P.O. Box 33200, Louisville, Kentucky 40233-3320, or to the address provided for filing an appeal on any written notice of an adverse decision that you receive from Us.

Upon Our receipt of your written or oral appeal at the appeals address or telephone number provided above or provided on any notice of an adverse decision, We will send you an acknowledgment within 5 business days notifying you that you will receive a written response to the appeal once an investigation into the matter is complete. Our acknowledgment may be oral for those appeals We receive orally.

Level 1 Appeals

Level 1 appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, We will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review your medical records and determine if the service is covered by your benefit document. If the clinical peer determines that the service is covered by your benefit document We must pay for the service; if the clinical peer determines that the service is not covered We may deny the services.

If you are appealing an adverse precertification decision other than a retrospective post-claim review decision (i.e., an adverse prospective, concurrent or retrospective pre-claim review decision) or the denial of any prior approval required by the Plan, We will provide you with a written response indicating Our decision within a reasonable period of time appropriate to the medical circumstances but not

later than 20 business days of the date we receive your Level 1 appeal request. If more information is needed to make a decision on your appeal, Anthem will send a written request for the information after receipt of the appeal. No extensions of time for additional information may be taken on these appeals without the permission of the member. Therefore, Anthem will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the appeal, We will provide you with a written response indicating Our decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 business days from receipt of the appeal request. If more information is needed to make a decision on your appeal, Anthem shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 business days of the appeal request, Anthem shall conduct its review based upon the available information, which review shall be completed within a reasonable period of time appropriate to the medical circumstances but not later than 40 business days from the appeal request.

Level 2 Appeals

If Our Level 1 appeal decision is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate a Level 2 appeal by contacting the Plan either in writing or by phone at the above address and telephone numbers. An acknowledgment will be sent to you within 5 business days upon Our receipt of your Level 2 appeal request. At Level 2, the appeal is reviewed by a panel of the Plan's staff members. We will set a date and time during normal business hours for Our appeal panel members to meet to discuss your Level 2 appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to

communicate with the appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not you choose to appear in person or by telephone.

Level 2 appeals concerning adverse precertification decisions other than retrospective post-claim review decisions (i.e., adverse prospective, concurrent or retrospective pre claim review decisions) or the denial of any prior approval required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Level 2 appeal request was received by Us. All other Level 2 appeals will be resolved by the panel no later than 45 business days from the date your Level 2 appeal request was received by Us.

After the appeal panel makes a decision you will be notified within 5 business days in writing by Us of Our decision concerning your Level 2 appeal.

Expedited Reviews

Expedited Review of a Level 1 appeal, or Level 2 appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available only if the medical care for which coverage is being denied has not yet been rendered. We will complete expedited review of a Level 1 appeal as soon as possible given the medical exigencies but no later than within seventy-two hours (72 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending Physician or ordering Provider, and the facility rendering the service. We will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending Physician or ordering Provider, and to

the facility rendering the service.

You may request an expedited review if a Provider with knowledge of your medical condition certifies that the absence of immediate medical attention will do any of the following:

- Place the health of the patient or unborn child in serious jeopardy,
- Cause serious impairment to bodily functions,
- Cause serious dysfunction of any body organ or part,
- Subject you to severe pain that cannot be adequately managed.

We, by applying a prudent lay person standard, may also determine that an appeal may be expedited.

External Appeals

If We continue to deny benefits for the service, you may request a review from another source. You may appeal issues for any of the reasons listed below:

- They are not Covered Services.
- They are not Medically Necessary.
- They are Experimental/Investigative.
- Issues regarding your eligibility, or
- Any other issue you have with your benefits

Denial Because Services are Not Covered

If We deny benefits for the service because it is not a Covered Service or We deny eligibility for coverage or for any other non-clinical issue, you may ask the Department of Insurance to review your claim. You can write the Ohio Department of Insurance at 2100 Stella Court, Columbus, Ohio 43215 or call the Department at 1-800-686-1526.

If your issue involves a coverage question, the Department will review your benefit document and the type of benefit requested. If the

Department determines that the requested benefits are not covered by your benefit document, We do not have to provide benefits for the service. If the Department determines the benefit is covered or that making the determination requires the resolution of a medical issue, We may either provide benefits for the service or provide you with the opportunity for a review by an independent review organization (described below).

Denial Because Services are Not Medically Necessary or are Experimental/Investigative

If We deny benefits for a service because it is not Medically Necessary according to your health plan coverage and the service and related expenses will cost you more than \$500 or the service has not been incurred yet and non-receipt of the service would jeopardize your life or health, you may request Us to obtain an external review from an independent review organization (IRO). Regardless of the cost of the service at issue, you may also request external review if We deny benefits for any service or supply because it is Experimental/Investigative. The IRO is not affiliated with Us. We pay the cost for the IRO review.

You must request this review from Us within 60 days of receiving notice of the result of the internal review of your appeal. Your request must be in writing except that if your Physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for external review is made, written confirmation of the request must be submitted to Anthem no later than 5 business days after the oral or electronic request is made.

The IRO will review your medical records and other relevant information to determine if the service for which benefits are requested is Medically Necessary or not Experimental/Investigative. If the IRO determines that the service is Medically Necessary or not Experimental/Investigative We must provide benefits for the service according to the terms of

your benefit document. If the IRO determines that the service is not Medically Necessary, We do not have to provide benefits for the service.

To qualify for this review you must meet all of the following criteria.

- You request an external review from Us not later than 60 days after receipt of notice from Us of the result of Our internal review or notice from the Ohio Department of Insurance that the determination requires resolution of a medical issue.
- You have exhausted all levels of our internal review process.
- The drug, device, procedure, or other therapy would be covered if it were not considered to be Experimental or Investigational.

Instructions For Requesting An External Review by an IRO

You (the Member) or your designated representative, may request an external review.

Your request for an external review must be submitted within 60 days after receiving notice from Us of the denial of Our internal review or after receiving notice from the Ohio Department of Insurance that the determination requires resolution of a medical issue. We will pay for the external review.

External review will be performed by an independent review organization (IRO). The IRO must provide Us with a response within 30 days of your request for an external review. The IRO's decision must include:

- A description of the patient's condition,
- The principal reasons for the decision,
- An explanation of the clinical rationale for the decision.

If the IRO determines that the service should be covered by Us, We must pay for the service according to the terms of your benefit document. If the IRO determines that the service should not

be covered by Us, We do not have to pay for the service.

Appeal Filing Time Limit

We expect that you will use good faith to file a Level 1 appeal or a Level 2 appeal on a timely basis. However, We will not review a Level 1 appeal if it is received by Us after the end of the calendar year plus 12 months have passed since the incident leading to your appeal. Unless there are extenuating circumstances, Level 2 appeals must be requested within 60 calendar days of your or your designated representative's receipt of the Level 1 appeal decision.

Appeals by Members of ERISA Plans

If you are covered under a Group plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Level 1 appeal prior to bringing a civil action under 29 U.S.C. 1132 §502(a). Level 2 appeals are a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while a Level 2 Appeal is pending. You will be notified of your right to file a voluntary Level 2 appeal if Our response to your Level 1 appeal is adverse. Upon your request, We will also provide you with detailed information concerning the Level 2 appeal, including how appeal panelists are selected.



Underwritten by Community Insurance Company

Notice of Privacy Practices

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003

THIS PRIVACY NOTICE IS PROVIDED

BY

Community Insurance Company dba Anthem Blue Cross and Blue Shield ("Anthem").

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties, and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect **April 14, 2003**. It will remain in effect unless and until we publish and issue a new notice.

1. **Our Commitment to Your Privacy**

As a company responsible for the information that we collect about you, your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place. These are designed to protect your information. We understand how important it is to protect your privacy. We will continue to make this a priority.

2. **Our Legal Duties**

We are required by applicable federal and state laws to keep certain information about you private. An example of this is your medical information. We treat your medical and demographic information that we collect as part of providing your coverage, as "Protected Information." It is our policy to maintain the privacy of Protected

Information in accordance with HIPAA, except to the extent that applicable state law provides greater privacy protections. This Notice of Privacy Practices was drafted to be consistent with the HIPAA privacy regulation. Any terms not defined in this Notice will have the same meaning as they have in the HIPAA privacy regulation.

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulation, might impose a privacy standard that we are required to follow. For example, where such laws are in place, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about HIV or AIDS, mental health, substance abuse, chemical dependency, genetic testing, reproductive rights, etc.

We reserve the right to change the terms of this notice. We may make the new notice provisions effective for all the Protected Information that we maintain. This includes information that we created or received before we made the changes. Any revised notice will be provided to you by one of the following means. (1) By mail to the named insured under the terms of your coverage. (2) By delivery of the notice by the named insured's employer if you are enrolled in employer-sponsored group insurance coverage. A copy of any revised notice will also be available on Anthem's web site.

Anyone may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact the appropriate office listed at the end of this notice.

3. **Our Primary Uses and Disclosures of Your Protected Information**

We may use and disclose your Protected Information without your specific authorization for the purposes of treatment, payment, and health care operations. To illustrate:

- **Treatment Activities.** Activities performed by a health care provider related to the provision, coordination or management of health care provided to you. We do not provide treatment, which is the role of a health care provider (your physician, a hospital or the like). However, we may disclose Protected Information to your health care provider in order for that provider to treat you.
- **Payment Activities.** Activities undertaken to obtain premiums or to determine or fulfill our responsibilities for coverage and provision of plan benefits. These include activities such as determining eligibility or coverage, utilization review activities, billing, claims management, and collection activities. For example, we may use Protected Information to determine whether a particular medical service given or to be given to you is covered under the terms of your coverage. We may also disclose Protected Information to health care providers or other health plans for their payment activities, such as to coordinate benefits.
- **Health Care Operation Activities.** Activities such as credentialing, business planning and development, quality assessment and improvement, premium rating, enrollment, underwriting, claims processing, customer service, medical management, fraud and abuse detection, obtaining legal and auditing services, and

business management. For example, we may use your Protected Information for underwriting, premium rating or other activities associated with the creation, renewal or replacement of a contract of health insurance or health benefits. We may also disclose Protected Information to other health plans or health care providers for certain health care operation activities of their own as described in the HIPAA privacy regulation.

We may also use your Protected Information to give you information about one of our disease/care management programs. We may also give you information about treatment alternatives or other health-related benefits and services that may interest you. If you are enrolled with Anthem through an employer-sponsored group health plan, we or your group health plan may disclose Protected Information to the sponsor of the plan, provided that the group health plan adopts certain protections required by federal law.

When using and disclosing your Protected Information in our payment and health care operation activities, we may only request, use, and disclose the minimum amount of your Protected Information necessary to complete the activity.

We may contract with others to assist us with treatment, payment or health care operation activities that involve the use of your Protected Information. Such third parties are referred to as our business associates. We require business associates to agree, in writing, to contract terms. These terms are specifically designed to safeguard Protected Information before it is shared with them. We may also have business associates assist in the activities described in the following section that involve permitted uses and disclosures.

4. **Other Uses and Disclosures of Your Protected Information**

You and on Your Authorization. We must disclose your Protected Information to you. This is described in the Individual Rights section of this notice, below. You may also give us written authorization to use or

disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law to) use and/or disclose your Protected Information without your specific authorization.

- **Family and Friends.** If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes a medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.
- **Research. Death. Organ Donation.** We may use or disclose your Protected Information for research purposes in limited circumstances specified in the HIPAA privacy regulation. We may disclose the Protected Information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
- **Public Health and Safety.** We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law.** We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your Protected Information to comply with workers' compensation or similar laws.
- **Legal Process and Proceedings.** We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.
- **Law Enforcement.** We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law. We may disclose the Protected Information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances specified by the HIPAA privacy regulation. We may also disclose Protected Information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and National Security.** We may disclose to military authorities the Protected Information of Armed Forces personnel under certain circumstances specified by the HIPAA privacy regulation. We may also disclose to authorized federal officials Protected Information required for

lawful intelligence, counterintelligence, and other national security activities.

5. Individual Rights

- **Access.** You have the right to inspect and obtain copies of your Protected Information for as long as your information is maintained in our designated record set. Our designated record set includes records from our enrollment, billing, claims, and medical management systems, as well as any other records we maintain in order to make decisions about your health care benefits. Your right of access to Protected Information does not extend to certain information. This includes information contained in psychotherapy notes or information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative proceeding.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. We reserve the right to charge a reasonable fee for copies of Protected Information that we provide.

Any request to exercise your individual right of access to your Protected Information must be in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. We will respond to your request for access within 30 days of receiving the request. If all or any part of your request is denied, our response will detail any appeal rights you may have with respect to that decision.

Notwithstanding the formal process for your right of access, certain information related to enrollment and claims processing may be available to you by contacting our Member Service representatives as part of our normal customer service function. You should contact Member Services first to see if your request can be satisfied as a customer service request.

- **Amendment.** You have the right to request that we amend your Protected Information

that we keep in our designated record set if you believe it is inaccurate. A request that your Protected Information be amended must be done in writing. You may obtain a form to request amendment by using the contact information listed at the end of this notice. We will respond to your request for amendment within 30 days of receiving the request.

If we accept your request to amend the information, we will notify you. We will make reasonable efforts to inform other persons, including those identified by you as having received your Protected Information and needing the amendment. We will also include the changes in any future disclosure of that information. If we deny your request for reasons permitted by the HIPAA privacy regulations, our notice to you will explain any appeal rights you may have with respect to that decision.

Notwithstanding the formal process for your right of amendment, certain information related to enrollment and claims processing may be corrected by contacting our Member Service representatives. This is part of our normal customer service function. You should contact Member Services first to see if your request can be satisfied as a customer service request.

- **Disclosure Accounting.** You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA privacy regulation to provide you with an accounting of certain types of disclosures.

The most significant types include:

- Any disclosures made prior to April 14, 2003
- Disclosures for treatment, payment or health care operations activities
- Disclosures to you or pursuant to your authorization
- Disclosures to persons involved in your care

- Disclosures for disaster relief, national security or intelligence purposes
- Disclosures that are incidental to a permitted use or disclosure

To request an accounting of disclosures, you must send a written request to the contact office listed at the end of this notice. You may request one such accounting at no charge every 12 months. You may request that the accounting cover up to a 6-year period of reportable disclosures from the date of your request. We will respond within 60 days of your request. We reserve the right to impose a reasonable charge for requests made more than once per year.

- **Confidential Communications.** You may believe that you will be in danger if we communicate Protected Information to you to your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by alternate means. We will make reasonable efforts to accommodate your request if you specify an alternate address. To request a confidential communication, you must direct your request to the contact office listed at the end of this notice.

- **Restriction Request.** You have the right to request that we restrict the use or disclosure of your Protected Information for treatment, payment or health care operation activities. You also have the right to request that we restrict disclosures to relatives, friends, or other individuals that may be involved in your care or payment for your health care. We are not required to agree to such a request for restriction. To request a restriction, you must direct your request to the contact office listed at the end of this notice.

6. Contacting Us

Please contact Anthem Customer Service using the contact information on your ID card:

- If you want a printed copy of our current notice
- If you want to access your Protected Information
- If you want to request an amendment to your Protected Information
- If you want to request an accounting of our disclosures of your Protected Information
- If you want us to communicate with you at an alternative address or by alternate means because you believe that you are endangered
- If you want to request a restriction on our use and disclosure of your Protected Information

If you have questions, concerns, or complaints about this notice or our privacy practices, please contact:

Midwest Privacy Operations Unit
(800) 880-1254

As described in section 5 of this notice, you may also be able to access or amend certain information in our enrollment, billing, or claims systems by contacting Member Services using the contact information on your ID card.

7. Contacting the Department of Health and Human Services

You may also submit a written complaint to the Department of Health and Human Services if you believe your privacy rights have been violated.

Anthem maintains and enforces a policy of non-retaliation against our members, members of our workforce, or members of the public who bring breaches (or potential breaches) of this notice to the attention of our privacy officer or the Department of Health and Human Services.

For more information, visit our web site at anthem.com.

IA-2003-130-6H

Group Name:

Marietta College

Group Identification Number:

00033832

Subgroup Identification Number:

Mail to group.

Marietta College